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FATHERS OF OFFSPRING WITH SEVERE MENTAL ILLNESS: KEY FACTORS RELATED TO FATHERS' PARTICIPATION IN CAREGIVING

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To my family

for their love and prayers

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Despite an abundance of research studies on family caregiving and mental health, the focus has been almost exclusively on the caregivng role of mothers, ascribing this responsibility inherently to women. Resent research findings have shown that mental illness occurs initially in a familial context, given the age of the first onset of the disease. How families manage mental illness is critical not only for recovery, but also for family's well-being. Fathers can play a significant role in the family to enhance the family's emotional, functional, and marital (or relationship) balance.

The purpose of this study is on creating new knowledge that can be applied towards increasing the involvement of fathers of offspring with severe

mental illness in caregivng roles. A sample of 104 fathers was purposively sampled from mental health organizations in Austin, TX, related conferences, and the Internet. The primary aims of this study are: (1) thoroughly review the recent and historical research literature to identify key factors that have an influence on active paternal nurture; (2) conceptualize a theoretical frame of reference that will increase our understanding of paternal caregiving; (3) identify and assess the instruments in the literature to measure key factors related to paternal caregiving involvement; and (4) identify and test a number of hypotheses that stem from the previous research.

Using hierarchical multiple regression, the impact of individualist and microstructural factors on the outcome of paternal involvement in caregiving was examined and discussed. The most important factor in predicting fathers' caregiving behavior is fathers' internalized sex-role orientation. High degree of masculine identity that defines nurture and care as feminine and unmanly seems to pose the greatest barrier for nurturing fatherhood. Other important predictors for active paternal nurture included paternal adjustment, socio-economic status, marital satisfaction, and the male gender of offspring with mental illness.

To produce more nurturing fathers, this study recommends social work interventions at both individual and social level. More balanced caregiving role allocation between mothers and fathers will reduce burden, stress, and depression of both parents and may promote happiness of the family that is caring for a member with severe mental illness.

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CHAPTER 1 INTRODUCTION

Statement of the Problem and Significance of the Study

Mental illness[1] is one of the most prevalent chronic diseases in the general population. The National Comorbidity Survey (NCS), the first survey to administer a structured psychiatric interview on a representative national sample in the U.S., effectively demonstrated that being affected by mental illness is normative. Results from the NCS showed that a lifetime prevalence of mental disorder was reported by nearly 50 percent of respondents, and about 30 percent reported experiencing at least one mental disorder in a one-year period (Kessler et al., 1994). Recent national statistics (CMHS, 2001) show that approximately 5.5 million persons were admitted to mental health services during 1997. The largest concentration of persons (3.3 million) were receiving treatment services in less than 24-hour care programs. In this setting, persons

[1]For the purpose of this study, "severe mental illness" is defined as "schizophrenia, schizoaffective disorder, major mood disorders, and severe personality disorders" as described in the DSM-IV (APA, 1994), Axis I and Axis II diagnosis (excluding mental retardation).

in ages 25 to 44 comprised the largest group receiving care (1.4 million admissions or 41 percent), followed by children and youth under age 18 (966,000 admissions or 29 percent) (CMHS, 2001). Mental health and mental illness issues are finally coming "out of the closet," even though public acceptance, and funding for treatment and prevention are still far behind the needs (Mowbray & Holter, 2002).

Three important findings emerged from recent empirical research studies synthesizing mental health and family caregiving literature. First, mental illness is among the most impairing of all chronic diseases, and persons with severe mental illness often meet lifetime criteria (Kessler et al., 2001; Kessler et al., 1994). Second, there is very little difference in the risk of severe mental illness by (familial) race or social class (CMHS, 2001; Heru, 2000; DHHS, 2001; U.S. Department of Health and Human Services, 1999; Lefley, 1997). And third, severe mental illness is highly correlated with age: mental illness has been acknowledged as having a typical onset during the adolescence or young adult years (CMHS, 2001; DHHS, 2001; U.S. Department of Health and Human Services, 1999; Cook et al., 1997; Lefley, 1997). Because severe mental illness tends to occur in adolescence and young adulthood, the family as a whole plays a critical role in providing and accessing services (Heru, 2000).

The research to date, however, focuses almost exclusively on the caregiving role of mothers of offspring with severe mental illness while leaving out other contributions in caregiving. Two major areas of familial caregiving have been neglected in the literature: First, research on low-income minority

fathers is very scarce. Although the empirical research evidence has shown that severe mental illness can occur in any family across racial and social class lines, previous studies were mainly conducted on a homogeneous sample of White, well-educated, and middle to upper-class groups (Curtis & Singh, 1996; Fuller-Jonap & Haley, 1995; Bailey, 1994; Lutzky & Knight, 1994; Harris, 1993; Rodrigue et al., 1992; Dyson, 1991; Vadasy et al., 1985; Linder & Chitwood, 1984). As a consequence, little knowledge is available about how fathers from diverse cultures or lower social classes perceive their roles in either caregiving for their offspring with mental illness or providing support and cognitive assistance to their families.

Second, the factors that determine how fathers of offspring with severe mental illness conceptualize severe mental illness or their own participation in caregiving are poorly understood. Because mental illness is rarely noted before adolescence or young adulthood, as reported in recent research findings (DHHS, 2001; U.S. Department of Health and Human Services, 1999; Cook et al., 1997; Lefley, 1997), parents are unlikely to be prepared to perform caregiving roles for their family member with mental illness. How each family member manages the crisis of having a member with mental illness may be closely related to the recovery of family homeostasis and stability. Given the empirical evidence that mental illness usually takes place in a familial context, it is very important to study the whole family more thoroughly in order to better understand the familial impact on the outcome of mental illness (Heru, 2000). However, factors that determine how fathers manage or

distribute their caregiving responsibilities and roles are poorly understood and generally disregarded in the caregiving and mental health literature.

The attitudes, roles, and mental health status of fathers were previously learned indirectly from their spouses (e.g., Coley & Chase-Lansdale, 1999); or in some cases, data on fathers were merged into the data on mothers to represent an overall parental rating (Rodrigue et al., 1992). Fathers of offspring with mental illness have a variety of needs based on their unique values and resources and on the specific characteristics of their offspring (Brotherson et al., 1986). Mothers' reports may be a convenient way to indirectly assess fathers but it may not be an accurate way to assess their attitudes, roles, and perception in terms of caregiving. Therefore, research studies that directly examine the relationship among various dimensions of fathering (e.g., attributes, child rearing attitudes, paternal role adjustment and role involvement) are needed.

Well-established research findings suggest that severe mental illness in a family member is a potential source of extensive stress and impairment in family functioning (Lefley, 1997; MacGregor, 1994; Frey et al., 1989b; Cook, 1988; Friedrich & Friedrich, 1981; Gallagher et al., 1981). Often, the family member with a severe mental illness is not perceived as carrying the most significant burden in the family. Depending on the severity of the mental illness and how it is manifested, the major burden may be on the parental caregiver (Hatfield, 1987). The stress of caregiving is positively correlated with the degree of cognitive deterioration. Caregiving for a person with severe mental illness is considered to be much more stressful than taking care of a

person with physical illness (Parsons, 1997; Hatfield, 1978; Cummings, 1976).

McConachie (1982) points out that when "caregiver" is used in American society, the term may in fact refer to the "female caregiver (mother)" only. Similarly, when the term "parents" is used in the research literature, fathers have not been differentiated from mothers, and the term often implied "mother" only (McNeil & Chabassol, 1984). The observation of how these terms, "family caregiver" and "parents" have been used, offers insight into the fact that the caregiving role has been perceived as an exclusive or natural role for women (mothers) in American society (Seligman & Darling, 1989). Attached to this is a widely held perception that "the mother is the root of the child's illness" because "the mother is at the heart of the family" (Greif & Bailey, 1990, p. 91). Fathers have been considered relatively unimportant when it comes to caregiving generally in the American family (Phares, 1996). Zoja (2001) points out the "growing rarity of father (p.232)" by saying, "Fathers have ceased to exist. The father gives ever more money, but ever less time to his children" (p.225). The absence of fathers in the caregiving context is evidenced by: limited participation in caregiving by fathers; professional supports and services for caregivers mainly targeting mothers; and the lack of empirical research findings on paternal involvement in caregiving and its influences on the family (Essex, 2002; Chesler & Parry, 2001; Culp et al., 2000; Curtis & Singh, 1996; Bailey, 1994; McConachie, 1982).

Objectives and Use of the Results

Due to increased maternal employment (Segal, 1990; Vadasy et al., 1985), divorce rate (Markowitz, 1984), women's movement (Furstenberg, 1988), and the relaxation of traditional parent (sex) roles (Griffiths, 1999; Rodrigue et al., 1992), the parenting role that heretofore defined mothers as the primary caretaker of offspring is changing. More and more, differences between paternal role and maternal role are diminishing (Kraemer, 1999). In accordance with these societal changes, increased father involvement is needed and there is a related need for more empirical study about fathers as caregivers.

Added to societal changes is the emphasis on family systems perspective which highlights fathers' role in families that have a member with mental illness (Heru, 2000). The family systems perspective suggests that all members in the family are influenced by a family crisis. Fathers are also considered important influences. Cook and associates (1997) emphasize the importance of viewing the entire family as a system because having a family member with mental illness influences every member of the family with its "ripple effect." The family may be thought of as a living, self-regulating system, which maintains constant exchange of information and energy, and each member is being influenced by each other (Goldenberg & Goldenberg, 1985). According to Seligman and Darling (1989), the father can trigger both negative and dysfunctional family dynamics by neglecting the family while its members struggle to cope with the extra pressures of caring for a family member with

mental illness. Meyer (1986a) further suggests that the father's ability or inability to manage family crises will influence the family's emotional and functional balance.

Research Objectives

This exploratory study is an initial step toward increasing our understanding of fathers of offspring with mental illness across racial and social class lines. One objective of this study is to thoroughly review the recent and historical research literature to identify key variables, research questions and research models. A second objective is to develop a theoretical frame of reference that helps explain differences in caregiving by fathers across racial and class lines. A third objective is to identify and assess the instruments that have been used in the literature to measure key factors associated with fathers of offspring with severe mental illness. The final objective is to identify and test a number of hypotheses that stem from the literature review of previous studies. The degree to which these key factors contribute to fathers' active involvement in caregiving will be examined with a sample of fathers of offspring with severe mental illness. The long-term purpose of this study is to establish new knowledge that can be applied towards increasing the involvement of fathers of offspring with severe mental illness in both affective and instrumental caregiving roles.

Research Questions

Question 1. Effects of Individual-level Factors on Paternal Caregiving

To what extent is paternal caregiving influenced by individual-level factors (i.e., father background and gender-related factors)?

Question 2. Effects of Microstructural Factors on Paternal Caregiving

To what extent is paternal caregiving influenced by microstructural factors (i.e., position within society, opportunities for caregiving role development, gender of offspring with mental illness, and family relationship)?

Hypotheses

Previous research studies provide scattered references to fathers' attitudes, feelings, and behaviors related to caregiving role. This study assembles the scattered information available from previous research, and proposes eight hypothesized relationships between paternal caregiving, and individual-level and microstructural factors. Research support for these hypotheses will be discussed later in Chapter 3.

It is hypothesized that fathers will participate more in caregiving role:

1. when the father has a greater feminine sex-role orientation;

2. when the father has a higher socio-economic status (SES) level;

3. when the father has a lower degree of work-to-family conflict;

4. when the father has a greater degree of positive perception toward the quality of fathering (caregiving) he received from his own father;

5. when the father is receiving stronger outside support for the paternal caregiving role;

6. when the offspring with mental illness is a son;

7. when the father is more adapted to the offspring with mental illness;

8. and, when the father is more satisfied with his marriage.

CHAPTER 2 LITERATURE REVIEW

Background Information

Transition of Fathers' Role in Families

Segal (1990) traced the evolution of changes in fathers' role in normative American families. Bristol and Gallagher (1986) proposed a very similar work, while focusing on the fathers of offspring with a disability. Due to the absence of relevant work on the fathers' of offspring with mental illness, both Segal (1990)'s, and Bristol and Gallager (1986)'s work is adapted below to view the transition of the father's role in families with a member with mental illness (Figure 1, p. 11).

In the 1950s (*unidirectional dyad*), the father's role in child development was considered unimportant or insignificant. Sigmund Freud and his followers strongly emphasized the relationship between mother and child while marginalizing the father, implying no true relationship existed between father and child. According to Zoja (2001), Neo-Freudian psychology has indirectly influenced the growth of individualism as it only focused on the primary relationships

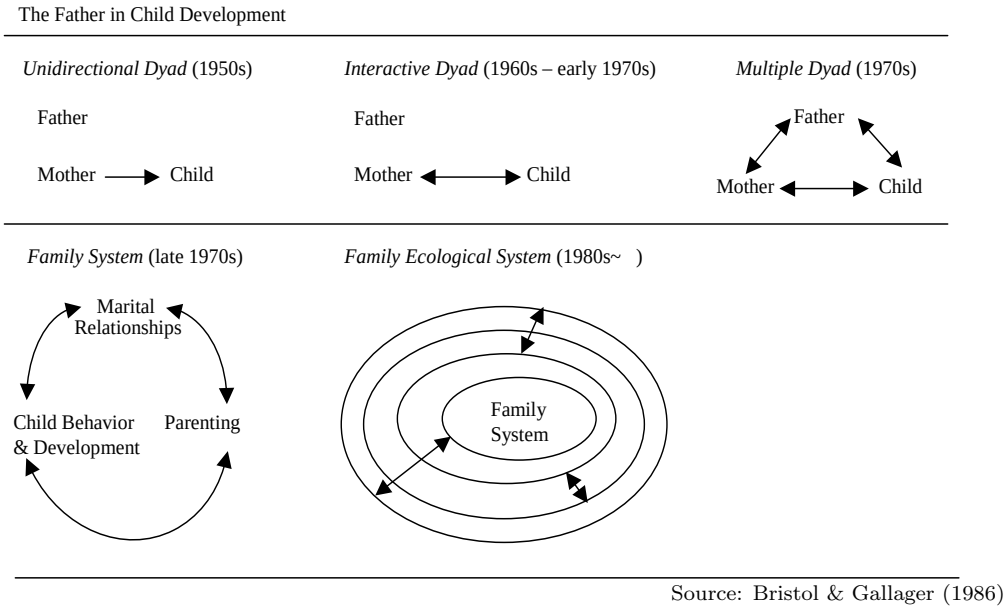

Figure 1: The Evolution of the Father's Role

(i.e., mother - child) and minimized the influence of social or collective dimensions (i.e., father - child) (For more information on psychoanalytic literatures about fathering, see Etchegoyen, 2002). Therefore, the father's role in the family was limited to the breadwinner role. Psychology introduced the idea that the father who failed in this role was either not fully mature or not fully masculine (Ehrenreich, 1983). At this time, mental illness was believed to develop merely from environmental influence, and the mother was perceived to be totally responsible for the socialization of her offspring with mental illness (Mowbray & Holter, 2002). Mothers were blamed for "creating" mental illness in their offspring, and accordingly, treatment approaches emphasized

the need to remove the flaws in parenting or to separate the "mentally ill" child from the "pathological" mother (Johnson, 1998a; McPeak, 1989).

Later in the 1960s to early 1970s (*interactive dyad*), the interaction between mother and child started to be acknowledged while the father's role remained insignificant. According to Segal (1990), fathers only appeared in research in response to the public worries that fathers' absence from the home would do harm to a boy's sex-role identity. Segal explains, for example, that research studies prior to the 1970s suggested that fathers' absence, which was especially common in African-American families, was responsible for creating hyper-masculinity, an *insecure but rigid acting out of the masculine role*, resulting in brute strength and violence.

Then, came the *multiple dyad* (1970s) that acknowledged both mothers' and fathers' direct influence on child development. New research on infants and their parents suggested that infants could also form attachment with fathers, overriding the previous attachment theory that an infant irreversibly bonds with its mother (Segal, 1990). Although the *multiple dyad* recognized the importance of fathers, it was limited in its assumption that it did not consider the relationship effect between the mother and the father.

In the late 1970s, the *Family Systems* perspective recognized the family as an interactive system, rather than a mere collection of individuals. Fathers were perceived capable of not only directly influencing their offspring but also indirectly influencing them by distracting maternal attention or by affecting mothers' parenting styles or attitudes. According to McPeak (1989), the family

systems perspective showed how the mental illness of offspring could develop from complex factors, and not just from a single cause. The concept of "circular causality" from the family systems perspective was helpful in changing the assumption that mental illness results from "simple (and linear) causes" and preventing "assigning blame or pathogenesis to any single piece of an interacting system" (McPeak, 1989, p. 61), such as the mother. A new way of understanding the vulnerability to mental illness emerged, combining genetic defect, environmental influence, developmental issues, and psychosocial factors (Mowbray & Holter, 2002).

Later in the 1980s (*family ecological system view*), Germain and Gitterman (1995) proposed seeing the entire family as one of an interactive, interdependent set of systems nested within each other. The basic idea of the family ecological perspective is to view people and environments as an integrated system and to have an overview of the whole picture at a macro-level. In this view, the child affects and is affected by the family system as well as by other systems of which the family is a part (Bristol & Gallagher, 1986). Starting from the eighties, according to Segal (1990), research studies started to address the importance of paternal participation in childcare, and study findings indicated that the low level of paternal involvement would result in higher depression and anxiety in mothers.

Paternal Caregiving Experiences

Review of recent literature shows that an extensive amount of research evidence exists on maternal caregiving experiences, confirming a high level of burden, depression and stress (Yee & Schulz, 2000; Howard, 1998; Heller et al., 1997; Mastroyannopoulou et al., 1997; Parsons, 1997; Opie, 1994; Belcher, 1988; Aneshensel & Pearlin, 1987; Cook & Pickett, 1987; Cook, 1988). Little is known about the caregiving experiences of fathers, or what personal or societal factors motivate them to increase their caregiving behaviors.

Two hypotheses related to caregiving and burden are discussed in previous literature. The adaptational hypothesis suggests that over the years, caregiving becomes easier and families adjust better to their caregiving role. On the other hand, wear and tear hypothesis suggests that the longer the period of caregiving, the more stressed experienced by the caregiver (Heller et al., 1997). In the literature, the adaptational hypothesis is generally more supported. Mastroyannopoulou and colleagues (1997) suggest that mothers and recently (less than 2 years) diagnosed families are most likely to experience serious caregiver burden. Regardless of the common assumption that the caregiver's burden will increase as the care receiver's condition worsens, Zarit, Todd and Zarit (1986) observed that the caregiver's tolerance level for the care receiver's condition increased by time, even though the care receiver's condition got worse. The study by Mastroyannopoulou and colleagues further suggests that the differences in subjective burden noted between men and

women diminished after 2 years, when they followed up their study. Similarly, in a meta-analysis study (Miller & Cafasso, 1992) synthesizing 14 descriptive studies of gender differences in caregiving, there were essentially no significant gender differences in terms of the level of caregiver's involvement in care, and the functional impairment of the care recipient. Both male and female caregivers responded to the demands of the situation, and their caregiving level did not decrease even though the functional impairment of care recipient became worse.

Mays and Lund (1999) interviewed 10 males who were primary caregivers for their family members with severe mental illness. In the study, the lack of understanding of mental illness and the care role were the main factors that resulted in the increased subjective burden of male caregivers. Lefley (1997) suggests that with the passage of time, what changes is the content of burden and not its magnitude. In a study by Belcher (1988), the level of caregiver burden and stress increased greatly when children with chronic mental illness become adults with high levels of dependency. The increased burden and stress of these parents may be due to the isolation from other parents their own age who no longer have dependent adult offspring residing with them (Belcher, 1988).

Kaye and Applegate (1990a) identified that those caregivers providing care out of reciprocity and nurturance were more satisfied with their caregiving tasks than those who performed caregiving tasks under obligation. Because caring is a gendered moral obligation for women, and "to care" is "to expe-

rience stress," women may possibly provide care out of duty and are often seriously stressed during the process (Opie, 1994; Kazak, 1987). Aneshensel and Pearlin (1987) state that because of different normative expectations for caregiving behavior, "the roles of mother are likely to be more time consuming and expansive, to invoke more areas of responsibility, and to be more disruptive of other social roles than the roles of father" (p.87). Chase-Lansdale, Wakschlag and Brooks-Gunn (1995) caution that negative effects of caring will occur when caring behavior results in substantial cost to the self: excessive caring behavior or caregivers' inability to distance themselves from the problem of those they care about will be detrimental to caregiver's mental health. However, for women, attempting to terminate or to refuse the caring obligation is not allowed, whereas for men, instrumental responsibilities are given priority over caregiving and thus they are allowed to maintain distanced position with limited commitment (Opie, 1994).

Gilligan (1982) proposes the "ethic of caring," and argues that responsibility or social obligation for caring others (a typical characteristic of women that she suggests) should not be regarded as a weakness in morality, but as a strength that fulfills moral responsibility. Individuals who adopt this ethic of caring will make judgments and actions based on their responsibilities to other individuals (Forsyth et al., 1988).

Interestingly, based on a study by Kaye and Applegate (1990a), caregiving men were motivated by the ethic of caring more than by a sense of duty. Caregiving men who strongly endorsed the ethic of caring and who fre-

quently showed affectionate behavior to their care receiver experienced less stress. May and Lund (1999) interviewed 10 male caregivers of a family member with severe mental illness, and researchers reported that male caregivers were committed to provide care as an expression of emotional attachment to the family member. In the study, all male caregivers were proud that they were committed to the caregiving role: "I am glad I am involved"; "It is good to know that a man can take care of someone and be proud of it (p.25)." In other study by Kaye and Applegate (1990b), "emotional gratification" was a critical motivating factor for male caregivers when they surveyed 148 men who are caring for a member with mental illness. Therefore, female caregivers who feel obligated to provide care, are more likely to report higher emotional involvement and depressive symptoms related to stress and burden compared to male caregivers who tend to provide care out of emotional gratification.

The fact that fathers are often absent from participating in affective or instrumental caregiving roles may be a key factor in explaining mothers' high level of burden, depression, and stress. Research evidence (Williams & Radin, 1999; Luccie, 1996) suggests the age of a child is closely related to the father's level of participation in caregiving. Fathers were more willing to get involved with their offspring when they are younger in age since young children require more attention and supervision. In addition, Markowitz (1984) suggests that the increased level of paternal caregiving participation is closely related to fathers' preference for their offspring. Although fathers tend to increase their involvement based on the offspring's age or personal preferences, many fathers

consider themselves as secondary caregivers who provide ancillary care, while attributing most of the primary caregiving to their spouse (Howard, 1998). When there is a need for increased caregiving responsibilities, families usually employ more traditional family pattern: fathers increase their efforts to provide for the family; and mothers concentrate on caring for their offspring at home. This is often based on a practical decision that it is better for the highest wage earner, usually the father, to focus on financial responsibilities (Einam & Cuskelly, 2002).

Furstenberg (1988), and Sagi and Sharon (1984) found out that imbalanced caregiving role allocation between fathers and mothers might negatively affect marital relationships. Segal (1990) also suggested that mothers who were totally in charge of providing care for their offspring with mental illness are more likely to get depressed, while the involvement of fathers in caregiving significantly reduced the depression level of mothers. In a study by Wintersteen and Rasmussen (1997), although fathers had increasingly become involved in caregiving behavior from the onset of their offspring's mental illness, their efforts were proven to be less than enough to balance the amount of time, energy, and caring devoted by mothers.

Little research evidence suggests that placing a family member with mental illness in out-of-home placements will reduce the perceived burden among parents, according to Heller and colleagues (1997). In a study by Seltzer, Greenberg, Krauss and Hong (1997a), researchers interviewed aging mothers with an adult child with mental retardation (n=308) or mental illness

(n=73), over a three-year period. The study hypothesized that the depression level of mothers of adults with mental illness would be reduced after the adult son or daughter moved to out-of-home placements, however, no such reduction was found. Researchers were amazed by the frequency of contact between these aging mothers and their sons or daughters after they moved away from home. This finding shows how the caregiving career persists even after the period of co-residence ended. Similarly, Mathew, Mattocks and Slatt (1990) found out there were no significant differences in terms of perceived burden between male caregivers residing with their relatives with dementia, and male caregivers who had institutionalized their relatives with dementia. In addition, there were no significant differences in terms of stress level between fathers of offspring with disabilities and fathers of normal offspring (Rodrigue et al., 1992; Houser & Seligman, 1991; McConachie, 1982). The implication given in these studies was that fathers have a tendency to be concerned more about financial issues rather than caregiving issue, and as a result, fathers may appear less stressed as caregivers and may be less burdened compared to mothers (McConachie, 1982). However, more recent research findings suggest that fathers of offspring with mental illness do experience serious negative psychological functioning due to the stress of caregiving, including depression and personality difficulties (Hornby, 1995). Howard (1998) interviewed 12 fathers of adult children with schizophrenia over a 2-year period. In Howard's study, fathers were asked to compare the caregiving experience with other difficult life experiences, and they said that caring for their children with schizophrenia

was the "the most difficult" or "the worst" experience. For example, one father in the study said, "This was the worst; loss of child due to death brought sympathy, and support from family, friends, and community. Loss of child to schizophrenia brought isolation, shunning, and situations hard to cope with, if not impossible (p. 408)." Fuller-Jonap and Haley (1995) compared elderly male caregivers to elderly non-caregiving men, using an all White sample, and found out that the male caregivers had poorer mental and physical health with more severe depressive symptoms.

Possibly, fathers may not participate in the caregiving role because they were not able to make a successful adaptation to their offspring's condition. In fact, research findings suggest that fathers have a more difficult time accepting and caring for their offspring with mental illness compared to mothers (Essex, 2002; Wintersteen & Rasmussen, 1997; Frey et al., 1989b; McConachie, 1982).

Paternal Adaptation to the Family Member with Mental Illness

Parents of offspring with mental illness must cope with the painful sense of loss and sadness that their offspring may not fulfill the dreams that the parents had hoped for them (Howard, 1998; Kelly & Kropf, 1995). There is a parental sense of "dual loss" with offspring with mental illness, according to Lefley (1997), about "the loss of the person who was, and the person who might have been given the person who was" (p. 444). Parents have to go through the adaptation process which takes a very similar form to a bereave-

ment process, mourning for the death of their perfect child who has been taken away through mental illness (Bicknell, 1988). Moreover, many parents are stigmatized as parents for having offspring with mental illness and are sometimes even blamed for the condition of their offspring (Mowbray & Holter, 2002). Still, the "mother blaming" is evident in clinical research, practice, and the society at large (Phares, 1996). As a consequence, the parents may feel guilty or responsible for their offspring's condition. By directly quoting a phrase, "a handicapped child is a handicapped family," Bicknell (1988) described the prevalence of negative stigma directed toward the parents of offspring with mental illness.

Limited research findings are available about what roles fathers play in the family adaptation process. But, it is generally supported in the literature that the gender of caregivers tends to determine their adaptation styles (Heru, 2000; Mastroyannopoulou et al., 1997; Lutzky & Knight, 1994; Rodrigue et al., 1992; McConachie, 1982; Price-Bonham & Addison, 1978). For example, Coley and Chase-Lansdale (1999) interviewed mothers for 3 years in order to study fatherhood (i.e., African-American fathers of 3-year-old children) in poor urban areas, and identified paternal education, employment, and strong or harmonious marital relations increase the likelihood that fathers will be highly involved with their children. But the study findings were not able to predict how paternal involvement will change over longer periods of time. In addition, parents of offspring with less behavioral problems are known to have higher levels of adjustment to their offspring's mental illness (Essex, 2002; Seltzer

et al., 1997b; Frey et al., 1989b; Frey et al., 1989a), regardless of parents' culture (Lefley, 1997). Mastroyannopoulou and associates (1997) suggested that mothers coped through emotional release while fathers coped through being practical. However, in this particular study, there was no evidence of which style of coping would be better in the long term.

McConachie (1982) observed that fathers either devoted themselves to or completely disconnected themselves from their offspring. The most often used defense mechanism of fathers was escape-avoidance and other commonly used defense mechanisms were distancing and positive reappraisal. Wintersteen and Rasmussen (1997) found out that employment and hobbies were considered opportunities for fathers to cope with their negative feelings (i.e., denial, shock, guilt, shame, etc.) toward their offspring with mental illness. In their study, fathers were more likely to participate in support groups or public activities only after they were able first to work out their painful feelings. Howard (1998) interviewed 12 fathers with offspring with mental illness over a 2-year period, and in his research, things that facilitated fathers acceptance of the mental illness included: "knowledge of the illness," "child's continued psychiatric help for the most part from competent doctors who assisted us through trying periods," "time and realization that problems would not go away," "Christian faith," "hoping for cure," and "love for my son" (p. 406).

It has been generally acknowledged in the literature that fathers seem to take longer than mothers to adjust (Essex, 2002; Wintersteen & Rasmussen, 1997; Frey et al., 1989b; McConachie, 1982) but there is limited empirical

explanation of why fathers have more difficulty in making this adjustment: Do fathers perceive severe mental illness in their offspring as a challenge to their "masculine identity"?; Does a father's pride in their offspring's potential achievements decline with the onset of severe mental illness?; Or, do fathers regret that they are not able to practice the traditional father roles (e.g., play mate, disciplinarian) with their offspring (McConachie, 1982)? Meyer and colleagues (1982) suggest that the level of father involvement may be influenced by their offspring's "qualities." According to Cook and Pickett (1987-88), based on a reciprocal socialization theory, a child is seen as being able to create its own caretaking environment by influencing the father's response. That is, the child acts as an important socialization agent for the father who is struggling to adjust to the mental illness of his child.

Public Policy and its Impact on Father Involvement

The United States has held a very strong belief that society must protect children from poverty which is known as the most persisting and devastating threat to caring children (Chase-Lansdale et al., 1995). In attempts to secure this belief, the state placed great importance on fathers' economic responsibility to support their children. The trinity of "God, Family, and Country" has always been strongly emphasized, and the family was defined as the union of a strong and responsible male with a prolific and self-sacrificing female (Ehrenreich, 1983). Often in research findings, there has been a strong correlation

between the poverty of a family and the absence of its father. As a consequence, the state played an active role in monitoring and regulating family life through public policies. Although the historical focus of welfare reform and polices have not been on fathers, but on mothers and children, more recent policies have sought to influence paternal involvement styles in the family.

Public policies have affected the construction of fatherhood, and have stipulated that the only "correct form of fatherhood" (Hearn, 2002, p. 254) is as breadwinners. In *Making Men into Fathers*, Orloff and Monson (2002) discussed how historical welfare policies and systems of social provision have been deeply gendered. Both welfare policies and social provision were established based on the gender division of labor, with men as breadwinners and women as primary caretakers.

In the colonial period, family structures were largely patriarchal and the father was the head of the household, responsible for children's overall well-being and education (Phares, 1996; Moran & Vinovskis, 1992). When a father failed to properly support or educate his children, the local government authorities interfered and removed the children from their home to place them in a more "adequate" household. The emphasis was on saving the impoverished child, and little attention was paid to the effect on the family. In the nineteenth-century, family continued to be seen as the center for rearing and educating children. Mothers (by race) were prohibited from working outside the home, due to the growing acknowledgement on the importance of mother-child relationships. Fathers continued to be viewed as breadwinners of the

family. In the late nineteenth-century, welfare policy toward children took a major shift. Based on the strong belief that mother-children relationship was sacred and should not be disturbed, it was argued that children fared best in their homes rather than in other households or institutions. As a result, the state concentrated its efforts to encourage and strengthen the family formulation (Chase-Lansdale & Vinovskis, 1995).

In the early twentieth century, fathers who deserted their families and children became a major social issue. A man's worthiness and authority in the home largely depended on his economic ability (Furstenberg, 1988). But in practice, most state authorities were unable to make delinquent or runaway fathers support their family. To take care of this matter, most states enacted public statues that made it a criminal offense for fathers to desert their families. Regardless of the increased efforts to make delinquent fathers support the family, the overall compliance rate was not very high (Chase-Lansdale & Vinovskis, 1995).

The fundamental image of the father as provider, however, started to fade during the Depression years (1930s) until the middle of the twentieth-century. As many fathers lost their economic standings, mothers often were permitted or forced to take on economic roles outside the home. Women's economic roles expanded even more during the war years, as they showed their abilities to work in the job market. The strict role division between fathers and mothers started to lose its ground (Furstenberg, 1988).

In this period, the Social Security Act was passed on 1935 in order to

aid poor White children. The Social Security Act had an important meaning because it was a permanent federal aid to provide welfare assistance to poor White children and old people. The Act also expanded the eligibility to receive assistance and supported poor children of separated, divorced, and never-married mothers through Aid to Dependent Children (ADC) (Chase-Lansdale & Vinovskis, 1995). It was a back-up program for the "failures of the family wage system for women" (Orloff & Monson, 2002, p. 72) who did not have husbands.

In 1962, the amendments to the Social Security Act further expanded the eligibility for public assistance and started to support families with unemployed fathers through the Aid to Families with Dependent Children (AFDC). After President Johnson declared a "War on Poverty" in 1964, more poor families received support from the state, and the stigma attached to welfare recipients reduced significantly. This contributed to a dramatic increase in the number of families on welfare assistance. As the War on Poverty ended up with greatly increasing the number of people on welfare roll, policy makers started to emphasize the economic self-sufficiency of women. Increasingly, women were viewed as having dual roles as mother and earner and were expected to have economic ability as well as ability to nurture children. This expectation was reflected in the Work Incentive (WIN) program in 1967, but was not successful. However, the early principle that poor mothers should stay at home with children was replaced with a new principle that welfare mothers should either receive job training or enter the job market (Chase-Lansdale &

Vinovskis, 1995). Welfare policies in the 1960s and 1970s, were gender neutral externally and did not enforce gender role differentiation, although the internal gendered division between male role and female role was unchanged (Orloff & Monson, 2002).

The image of the father as the economic provider continued to decline in the 1970s. The feminism movement proposed a future in which "no adult person was either a dependent creature or an overburdened breadwinner" (Ehrenreich, 1983, p.116). And fathers were no longer burdened with the fixed expectation of marriage and breadwinning. It seemed to Ehrenreich (1983) that on the fundamental level, the feminism movement was not triggered by women's oppression but by the decay of the male role, surrendering to the exhausting family burdens. Goldberg (1977) stated that masculine privilege was "a myth" and guilt for leaving family was "one trap from which the liberated man *must* free himself" (p. 162). As fathers were freed from the excessive burdens of the good-provider role, an increasing number of fathers became absent from their families (Chase-Lansdale & Vinovskis, 1995).

In the 1980s, there had been concentrated government efforts to reinstate fathers' economic responsibilities. Ehrenreich (1983) reported this period experienced the "feminization of poverty," as the sociologist Diana Pearch phrased, and the number of poor women greatly increased. The fastest growing poor population were single mothers, raising and supporting children on their own. Previously, father absence was viewed mainly as a family problem, but in this period, the state started to become actively involve in this

matter (Chase-Lansdale & Vinovskis, 1995). The Family Support Act of 1988 required states to establish paternity for all out-of-wedlock children and required all unmarried fathers to pay child support until their children reached age 18 (Cabrera & Evans, 2000). Inherent in these coercive policy efforts was the belief that stronger measures were necessary for keeping fathers from deserting their economic responsibilities. The fundamental belief behind this policy direction was that fathers must financially support their children, and marriage is the means through which men as breadwinners are compelled to support their families (Dowd, 2000; Ehrenreich, 1983): "good-families" are male-headed families (Segal, 1990).

In the mid twentieth-century, fathers stood in a position of increased responsibilities, both financially and morally, through the action of public policies (Hearn, 2002). The 1996 Personal Responsibility and Work Opportunity Reconciliation Act forced mothers who were on welfare assistance to leave the welfare rolls and move toward self-sufficiency. Although the main focus of welfare reform was not on fathers, it required mothers to establish paternity for children born outside of marriage, and required fathers to pay child support. An implicit assumption behind this enforcement was that, within marriage, children are best benefited, but that outside of marriage, children will be inadequately supported. Based on this view, coercive policies are essential to secure adequate child support. Such policies for delinquent fathers with child support obligations include: instituting property liens, intercepting tax refunds and lottery winnings, invalidating professional and recreational

licenses, denying passports, and booting cars. In addition, the state or either parent can request genetic testing in order to establish paternity, and in some states, a default paternity findings will be issued if the alleged father does not cooperate (Cabrera & Evans, 2000; Peters, 2000).

In conclusion, historically, fathers have been mainly regarded as economic providers. "Deadbeat fathers" (Furstenberg, 1988, p. 193), or fathers who refuse to support their children, were the only group of fathers that gained keen attention in welfare policy formulation. As a consequence, coercive federal and state laws were enacted trying to enforce paternal responsibilities (Dowd, 2000; Furstenberg, 1988). Other than those deadbeat fathers, fathers in general received little attention in welfare policy formulation. Generally speaking, fathers have been relatively invisible in such policies, and it has been paralleled by the lack of research attention and research evidence about paternal involvement in child caregiving.

Limited Professional Supports and Programs for Fathers

Economic responsibility has been the foremost valued virtue of good fathers, historically. Fathers of offspring with mental illness are even more burdened by the economic responsibility while trying to pay medical and treatment bills. According to Mays and Lund (1999), male caregivers were predominately burdened by financial strain and social role disruption. These burdens caused fathers to experience frustration and irritation. Neverthe-

less, support groups and programs specifically targeting fathers are extremely scarce. A large number of treatment and support programs including parent groups, parent meetings, and parent conferences have been directed toward mothers (Essex, 2002; Howard, 1998; McNeil & Chabassol, 1984). Chesler and Parry (2001) comment that "the broader Western culture frames men's and women's lives in ways that make the situation of parenting ill offspring distinctively traumatic for men" because "gendered assumptions about masculinity and fatherhood are embedded (and reinforced) within the social organization of relationships and medical and work settings" (p. 373).

Linder and Chitwood (1984) observed an existing communication gap between the professionals and the fathers, using a predominantly White sample of 152 fathers of infants and preschoolers with handicaps in urban and rural Colorado. This communication gap may have resulted from the fact that most information is disseminated through mothers. Also, Erickson (1974) interviewed fathers of children with Down's syndrome and identified that fathers expressed concern about the insufficient information they were receiving from the professionals. As a consequence, fathers may have negative reactions to professionals, as reported by Hornby (1992).

The importance of collaboration between professionals and families is strongly emphasized for the successful treatment of offspring with mental illness (DeChillo, 1993). The lack of parental involvement in decision-making for their offspring's treatment was identified as a major factor in generating parental dissatisfaction with professional services (DeChillo et al., 1994). Rely-

ing on mothers as the primary communication source and disengaging fathers during the helping process may distort information and it may further have a negative effect on the family system (Linder & Chitwood, 1984). Seeking fathers' input and encouraging their involvement throughout the helping process are critical for successful treatment outcomes.

An important reason why professional support services result in disengaging fathers may be because many workers in such services were themselves mothers, and they preferred working during the morning hours. And as these service hours conflicted with most fathers' work schedule, they were deprived of opportunities to participate even if they wished to be actively involved in the services for their offspring (Sagi & Sharon, 1984).

Professional supports and programs play a critical role in the successful adaptation of mothers (Donovan, 1988). Curtis and Singh (1996) surveyed a sample of 153 predominantly White parents of children with emotional and behavioral disorders, and identified that because the service delivery system was directed toward mothers, they perceived themselves as both more empowered and more involved in services for their offspring than the fathers. As a result, fathers were provided with fewer opportunities to share their concerns and to reduce their stress (Meyer, 1986). A preliminary finding from a father's support program evaluation, with a sample of 23 White, middle-class and well-educated fathers, indicated that fathers also benefited from formal services as evidenced by their decreased level of stress and depression, and higher level of satisfaction (Vadasy et al., 1985). The important role of support in suc-

cessful paternal adjustment was also discussed in the study by Kazak, Stuber, Barakat, Meeske, Guthrie, and Meadows (1998). In this study, 331 parents of 6-to-20-year-old survivors of childhood cancer were sampled and the data proved the importance of support in reducing parental anxiety and stress in the short and long term. Therefore, fathers should be provided with choice of programs that match their own needs and concerns (Meyer, 1986).

Lack of Services for Families of Diverse Cultures

There are even less services available for the families with diverse cultural backgrounds. The lower usage of formal and support services by families of diverse cultures is thought of as a reflection of their greater resilience, distrust of formal services, and cultural beliefs that families should take care of their member with mental illness. For example, many African-American men tend to go without treatment, ignoring warning signs of the onset of a mental illness because they believe they can tough it out. The epidemiologist Sherman James (as cited in Harris, 2001) suggests that the "strength itself can become a disease in some African-American males" (p. 38) because it is difficult for them to accept illness and seek treatment. According to James, the "John Henry Syndrome" is a definition of black masculinity based on brute strength, and it is a condition that exists in most African-American male population:

> Many black men, who have been taught to rely on their own bodies more than anything else, have simultaneously been taught-through history, popular culture, and their own communities-that

> their bodies are physically superior to those of the frail, "puny" white men who enslaved them. This superior physical strength therefore enables them to endure-and withstand-extreme physical duress.... He will ignore such discomfort to the point where it becomes irreversibly detrimental. Thus many more black men die from curable ailments because of their belief in their bodies and their strength... (p. 38).

The fact that families of diverse cultures are not active consumers of mental health services has been misused to make arguments that the lower usage of services is their own decision, and it will be inappropriate and disrespectful to direct resources to these families. Cultural barriers to accepting needed mental health services may be of certain concern. However, the utmost barrier reported by families of diverse cultures was not related to cultural differences but the language issue. McCallion, Janicki, and Grant-Griffin (1997) held a series of focus group meetings with African-American, Chinese-American, Haitian-American, Hispanic/Latino-American, Korean-American, and Native-American families, caregiving for persons with developmental disabilities. They agreed that language barrier was a major obstacle to getting information about available services, expressing their needs, and receiving help and support from service providers. Many families expressed great interest in receiving services from agencies if there were staff members who could speak the family's primary language. Lack of agencies that are based in and operated by their own cultural communities seemed to prevent these families of diverse cultures from receiving needed services (McCallion et al., 1997).

Domains of Family Caregiving

Human, like other mammals, have a need to belong throughout life. It is a generic human tendency to bond with their infants and to seek persistent caring (Rossi, 2001). Families are a instrument in which the promotion of "caring" occurs between individuals. The fundamental component of caring is considered as "the experience of being loved, with the resultant capacity for sensitive responsiveness to the needs of others" (Chase-Lansdale et al., 1995, p. 517). Caring results from the emotional response (i.e., empathy, sympathy) but it should be followed by caring behavior (Chase-Lansdale et al., 1995).

Lee (1992) has identified three domains that comprise family caregiving: domestic labor, nurturance in family role behavior, and kinship relations. Differences between fathers and mothers in terms of caregiving are closely related to their differences in each of these three domains. Each of these domains, in turn, has implications for identifying differences between mothers and fathers in terms of caregiving. More importantly, Lee's caregiving domains allow us to understand how fathers were excluded from the concept of caregiving.

Domestic Labor

Due to the consistent emphasis on deinstitutionalization that started in the 1950's, increasing numbers of persons with even the most severe and profound mental illness now reside at home with their parents (Mowbray & Holter, 2002; CMHS, 2001; Johnson, 1998a; Cook et al., 1997). As a conse-

quence, the majority of care for the family member with mental illness usually takes place in the home. In a study of family caregivers by Noelker and Bass (1989), family caregivers seemed to carry an internal expectation that they should try to refrain from taking outside help as long as they could. As self-efficacy is highly regarded in the American society, many family caregivers appear to exhaust their emotional as well as their financial resources before seeking outside help.

Traditionally, mothers have routinely performed domestic labor. Caring for offspring with mental illness parallels the routine personal care and household chores that are obviously classified under domestic labor which has been the mothers' responsibility (Lee, 1992). White (1994) argued that as fathers worked outside of home they were freed from caregiving responsibilities at home. Even if fathers participated in caregiving for their offspring, they seemed to choose a task that is more pleasant or a task that they are willing to do (e.g., playing with them). Mothers were left alone to deal with the rest, such as washing, feeding, and dressing their offspring (Segal, 1990). In a 4-year longitudinal study (Bailey, 1994) of 22 White, intact, and middle-class families, mothers were the ones who generally took charge of the caregiving role regardless of their employment status. Even though fathers participated in caregiving tasks for their offspring with mental illness, they felt more burdened by such tasks compared to mothers (Heller et al., 1997).

As caregiving is commonly classified under domestic labor which has been traditionally considered mothers' responsibility, fathers may not view

caregiving as their work. Accordingly, even when fathers and mothers both worked outside the home, mothers are likely to remain as the primary caretakers of their offspring (Culp et al., 2000). The mother's work does not necessarily mean increased participation in the caregiving role on the father's side (Harris & Morgan, 1991; Markowitz, 1984). Walker (1992) comments that employment outside of the home "does not prevent women from caregiving: it seems only to prevent men" (p.40).

Nurturance in Family Role Behavior

Caregiving has been mainly defined as a female activity with the emphasis on nurturance; and, this definition of caregiving failed to include authority issues and supervisory activities (e.g., coordinating care and medical needs) that are usually done by fathers (Chesler & Parry, 2001; Furstenberg, 1995; Miller & Cafasso, 1992). In addition, paternal involvement has been examined solely from instrumental or financial contributions, which had restricted overall understanding not only of its effects on the child, but also of the multiple, interactive roles in which fathers may play. Moreover, measuring paternal involvement with fathers' economic abilities is problematic for low-income or unemployed fathers. Johnson (1998b) studied the paternal involvement of low-income African-American fathers, and observed that those fathers had been experiencing great difficulty in assuming the financial provider role, due to their weak labor force attachment. Roy (2000) interviewed 40 low-income fa-

thers in Chicago, and realized that forcing disadvantaged fathers to become workers first and parents second could ultimately discourage paternal involvement in the family (Roy, 2000). As fathers, however, their inability to provide financial support does not necessarily suggest that they are not participating in their children's lives. Recent research findings (Howard, 1998; Johnson, 1998b) suggest that many of these low-income or unemployed fathers were compensating their economic inability by spending more time with their children. This level of physical and emotional involvement with children may have far greater meaning and impact for the children than many distant fathers who just provide financially for their children. However, recent and historical research studies have failed to value or realize this type of paternal contribution. The affective and nurturing contributions of fathers also deserve to be included in the framework for assessing paternal involvement (Peters, 2000). Johnson (1998b) pointed out a need for a "broader, integrative framework for examining and assessing paternal involvement that enhances the range of roles and opportunities" (p.218). Positive father involvement is not only beneficial for the family but also helpful for fathers' own development (Cabrera & Evans, 2000)

Largely due to the fact that mothers can have babies and fathers cannot, nurturance is considered mothers' unique behavioral pattern. In the same way, women have been regarded as the primary source of long-term care for the elderly in the gerontological literature for the last 30 years (Harris, 1993). Some men are found to be involved in care for older people, but most male

caregivers are husbands (Stoller, 1990). Regardless of the widespread belief that mothers are natural caregivers for their offspring with mental illness as well as for the elderly, no empirical basis exists to argue that women inherently have a superior capability for loving, caring, supporting, and nurturing. Indeed, women's birth giving ability has been worshiped historically, as the statues of the goddesses of fertility can be found in every archaeological museum (Lorber, 2003). However, Lorber cautions that women's birth giving ability should not subordinate nurturance to women. Sagi and Sharon (1984) suggest that such beliefs may only have resulted from social values and norms that define women as natural caregivers. Opie (1994) suggests that gender has been identified as a major social policy issue embedded in social expectations, and "caring" has been considered women's natural behavioral pattern or the instinctual ability. Due to this myth that mothers have maternal instinct to care for their children, mothers are often blamed for children's psychological problems, while fathers were kept safe from being blamed (Phares, 1996). One example of these gendered role expectations is that mothers generally report receiving less support from their spouses than fathers. Chesler and Parry (2001) state that "traditional cultural definitions of male roles shape mothers' and fathers' relations with one another, their ability or willingness to share new (or old) household and childcare tasks, and their support for one another" (p. 378). In a study of 55 parents of offspring with cancer, Chesler and Barbarin (1987) observed that 92% of men reported their spouses as "very supportive" to them during their offspring's illness, whereas only 59% of women made such

a report. Aneshensel and Pearlin (1987) caution that when the mother experience emotional difficulties while performing the caregiver role, it may develop additional problems in performing other roles in the family. Spousal support and resulting marital satisfaction are acknowledged to be effective in buffering negative effects from taking care of offspring with mental illness (Essex, 2002; Lefley, 1997).

Unsurprisingly, in the mental health literature, mothers have been the most researched family member, after the person with mental illness. Fathers are discussed far less than adequately in the studies on family caregiving. In part, this may be due to the fact that fathers are more difficult to identify and are more difficult to get consent from to participate in the studies (Chesler & Parry, 2001; Horowitz, 1992; Mathew et al., 1990). But more importantly, it reflects the fact that mothers who gave birth to offspring are undoubtedly considered natural caregivers (Draper, 1998; Seligman & Darling, 1989). As the caregiving role responsibility has been differently allocated by gender, fathers may be less exposed to caregiver role-bound stressors than mothers (Lefley, 1997; Heller et al., 1997; Aneshensel & Pearlin, 1987). Rossi (2001) suggests to direct our attention on what prevents fathers from caring. Just like mothers, fathers may experience the same social pressure to provide care, but it is likely that they feel more pressure to make financial contributions. Furthermore, the belief about women's inborn ability to care may have affected fathers' unwillingness to take on more responsibility in terms of caregiving (Segal, 1990). Because the nurturing contribution of fathers has been disregarded in large

part, most fathers were deprived of the necessary opportunities to move away from the existing normative system and to open up their potential capability for caregiving.

Kinship Relations

Traditionally, the father's role has been narrowly restricted to being a child's playmate (Meyer et al., 1982) or breadwinner (Zoja, 2001). This traditional father role has minimized the father's role in kinship ties and they were able to either increase or decrease their involvement based on their personal preferences and satisfaction with their offspring. On the contrary, mothers have been considered "kin keeper" (Lee, 1992) and have been expected to show strong kinship ties to all of their offspring and others in need (Essex, 2002; Lamb, 1983). Mothers were thought of as playing an important role in linking the father to the child (Draper, 1998). Cook (1988) suggests that these traditional parenting roles tend to be reinforced even more in families with a member with mental illness. Regardless of the severity of the environment, the father may never have been under the same selective pressure that is subjected to the mother (Zoja, 2001; Draper, 1998).

Meanings attached to the traditional father role as playmate are starting to diminish, however, and it is more of the case with the offspring with severe mental illness (Gallagher et al., 1981). If fathers assume the traditional playmate role with their offspring with mental illness, it would have

little meaning because many fathers might not know any appropriate ways to play with their offspring (McConachie, 1982). The "image of fatherhood" is changing nowadays as the result of cultural shift – "from the disengaged breadwinner and unemotional disciplinarian to the *new father* who is expressive, nurturing, and intimately involved in his offspring's daily lives" (Harris, Furstenberg, & Marmer, 1998, p. 201). Basically, this image of the new father is not different from mothering. The new father role is a combination of the traditional paternal and maternal roles (Harris & Morgan, 1991). It is becoming more apparent that offspring need their fathers just in the same ways as they need their mothers (Kraemer, 1999). According to Furstenberg (1988), the "breakdown of the good-provider role for fathers is responsible for generating the good dad-bad dad complex" (p. 215), categorizing fathers into two groups of caring fathers and non-caring fathers.

Segal (1990) suggests that fathers have gradually become more dissatisfied with the narrowly defined fathering role that they grew up with and, in return, are exploring new roles. However, even though fathers want to increase their involvement in kin relations and caregiving tasks, there is little empirical ground concerning what the "current appropriate" role of fathers is (Coley & Chase-Lansdale, 1999). Little guidance is available from research to assist in this transition from traditional father to the new father. More studies that explore fathers' own definitions of being a father, and the meaning of fathering fathering role are needed to accelerate the development of "appropriate" role models for fathers (White, 1994).

CHAPTER 3

CONCEPTUAL FRAMEWORK

Individualist Perspective

The individualist perspective presumes that gender roles are internalized as stable personality traits. An individualist paradigm suggests that by adulthood, men and women have developed very different personalities through child-rearing techniques and gender-appropriate role socialization (Risman, 1987). Bem and Bem (1976) argued that due to the powerful nature of this gender-role socialization, adults were left with few choices in their roles. Through the socialization process, women have become "nurturant, person-oriented, and child-centered," and men have become "competitive and work-oriented" (Risman, 1987, p. 7). In Carol Gilligan's (1982) account, "male gender identity is threatened by intimacy while female gender identity is threatened by separation" because "masculinity is defined through separation while femininity is defined through attachment" (p. 8). A study by Markus, Ryff, Conner, Pudberry and Barnett (2001) support the notion that women

are more interconnected with others compared to men. After interviewing 83 men and women, researchers coded their self/other responses. Compared to women, men mentioned "self" much more in great frequency than they mentioned "others."

There was an attempt to explain behavioral differences in caregiving between men and women by their hormonal differences (Rossi, 1984; Rossi, 1977). According to Rossi's biosocial account, women show caregiving behavior because their hormones direct them to do so.

It is the psychological account, however, that is the most widely accepted individualist explanation for gender differences in caregiving. The psychological perspective presumes women are natural caregivers and nurturers. Caregiving is considered central to women's identity, and the main motivation factor for women's caregiving is believed to be their attachment to their offspring (Walker, 1992). Nancy Chodorow (1978) argues in *The Reproduction of Mothering* that women reproduce "the sexual and familial division of labor in which women mother" (p. 209) through devoting their energies toward nurturing and caring for offspring. On the contrary, men were seen as having a basically different identity from women, and their way to show attachment to their offspring was to participate in the labor force to provide economic support (Walker, 1992). According to Risman (1987), "mothering," which is the task to provide physical maintenance and nurturance, is "one of the few behaviors that appear almost universally gender specific" (p. 11). Again in *The Reproduction of Mothering*, Nancy Chodorow argues that "women grow

up with the relational capacities and needs, and psychological definition of self-in-relationship, which commits them to mothering" because "women are themselves mothered by women" (p. 209). However, men do not commit themselves to mothering, according to Chodorow, because they were mothered by women. While women became mothers through the "reproduction of mothering," fatherhood was perceived to be a "biological fact, part of the social associations of marriage, taken for granted, part of the definition of the 'head of the household' and reinforced by legal or communal practices" (Hearn, 2002, p. 254).

In sum, the implicit presumption of the individualist paradigm, in Risman's (1987) account, is to view caregiving as "primarily a women's activity not because of the social organization of work or kinship, but because women psychologically desire to 'mother' and men do not" (p. 11). In this account, gendered behavior, such as mothering or caregiving, is seen as the result of internalized gender traits.

Microstructural Perspective

A microstructural perspective suggests that differences between women and men mainly resulted from differential placements, experiences, and opportunities within social networks. Social roles of women and men are constructed through the constrained processes of teaching and learning; "Whatever genes, hormones, and biological evolution contribute to human social institutions is

materially as well as qualitatively transformed by social practices" (Lorber, 2003, p. 11). In Hearn's (2002) account, "fathers and fatherhood are social, rather than *natural* or biological, constructions and institutions, intimately connected with the social production and reproduction of men, masculinities and men's practices" (p. 245). In a microstructural approach, gendered behavior is not presumed to be fixed by early gender-role socialization or biological conditions but rather it is adaptive to ongoing interaction (Risman, 1987). For example, according to Miller and Cafasso (1992), "situation-specific role demands, support resources, and personal dispositions will influence the enactment of the caregiving role and the appraisal of caregiver distress," and "the stress process is conditioned by such attributes as gender, age, and race, which are associated with differential exposure to structural barriers and opportunities" (p. 499). Neff and Harter (2002) suggest that women's other-oriented relationship behavior does not reflect their true self. In other words, women have been placing priority on meeting others' needs in relationships, not because it is their natural tendency (i.e.,reflection of true self), but because the other-oriented relationship behavior is reinforced through social roles and situations.

A microstructural perspective does not necessarily deny the influence of internalized gender trait for explaining differences in gendered behavior (i.e., caregiving) between men and women. However, a microstructual paradigm finds a more salient explanation for gendered behavior from the "social construction of gender role," through the influence of social support, employment,

family interactions, and relationship between the caregiver and care receiver.

The social constructionist perspective, based on the microstructural account, views fatherhood as an ongoing process that involves the creation and recreation of roles through observation, communication, and negotiation (Chesler & Parry, 2001; Daly, 1995). According to Chesler and Parry (2000), this process of social construction of paternal role often limits men's options in developing role behavior. For example, De Luccie (1996) observed in her study that there were no significant relationships between child-rearing attitudes and actual role involvement. Parents may report they hold an egalitarian view toward women's social roles and expect that fathers will be involved in caregiving. However, when their child is born, it is the mother who usually assumes the primary caregiver role and the father takes a minimal role in caregiving (Fishbein, 1990). This gap between egalitarian views and behavior may have resulted from existing traditions, social values, norms, and standards about gendered behavior, which has limited the way that paternal roles are constructed (Daly, 1995).

Hearn (2002) and Segal (1990) suggest that power is the most prominent factor in understanding men's resistance to change in role behavior. According to Hearn (2002), "fatherhood has historically been an institution of power" (p. 254) and "the status of *father* still involves getting something, some power, status and certain rights, for (almost) nothing" (p. 255). In White's study (1994), fathers state that they felt they earned social status as a result of becoming a father: "People look up to the family man" (p. 123); "If a bloke

hasn't settled down and made a family, he's missing out on the acceptance that comes with being a parent" (p. 124). Fathers have been mainly defined in terms of rights in relation to offspring and women while mothers have been continuously defined in relation to responsibilities (i.e., caregiving). Similarly, a recent study by Neff and Terry-Schmitt (2002) examined beliefs about power-related gender-role traits, using 264 adolescents and young adults, and found out that males believed men to have higher levels of powerful masculine traits (i.e., has leadership ability, dominant, independent) than females did. In addition, females believed women to have higher levels of submissive female traits (i.e., compliant, gullible, and sensitive to needs of others) then males did. This study (Neff & Terry-Schmitt, 2002) further suggested that these sex differences in power-related gender-role traits were more firmly believed by older participants than younger participants.

In sum, a microstructural perspective suggests that situational factors and demands, rather than internalized gendered-traits, are responsible for preventing men's role development in caregiving (Risman, 1987).

Macrostructural Perspective

The macrostructural perspective presumes direct causal relationships between societal conditions and human action. Therefore, the macrostructual approach suggests that macro-level social determinants are responsible for generating different gendered behavior between men and women (Cook

et al., 1997; Risman, 1987).

Aneshensel and Pearlin (1987) explain that gender differences in social role occupancy and experiences may have resulted from "sex stratification of the social system" (p.76). Based on the sociological perspective, Walker (1992) comments that "social expectations impel women into, and propel men away from, caregiving" (p. 39), and through this socialization process, attitudes and behaviors attached to gendered role are being internalized. Cook (1998) tries to answer the question, "who 'mothers' the chronically mentally ill?" in her study, and concludes that only the mothers *mothers* them because "cultural expectations about gender and child rearing resulted in an unequal sexual division of labor in illness management for mothers and fathers" (p.43). In this macrostructural account, caregiving is more of "a reflection of mothers' place in the broader social system" rather than "a natural expression of a woman's personality or feelings toward others" (Walker, 1992, p. 41). In other words, women provide caregiving because of "the low value placed on the work of women; social disregard for the costs of caregiving to women; and lack of government support for meeting the needs of its citizens" (Walker, 1992, p. 41). Whether women desire this role becomes unimportant, since their societal self-worth is based on their performance in this role.

Hearn (2002) argues that macrostructural factors including "religion, science, law and welfare reforms have all stipulated 'correct' forms of fatherhood and the patriarchal family" (p. 254). According to Chase-Lansdale and Vinovskis (1995), the key motivation underlying welfare reform is the strong

belief that fathers must economically support their offspring. Increasingly, the government takes control over who can become a father, implying that only a man with financial ability should become a father (Hearn, 2002).

Macrostructural factors also determine the patterns of formal and informal support and treatment options for families with a member with mental illness (Chesler & Parry, 2001). For example, the public policy's emphasis on deinstitutionalization has forced families to assume the primary caregiver responsibility for their offspring with mental illness. The deinstitutionalization movement, starting from the 1950s, occurred in response to multiple social forces including: a sense of optimism about patient functioning resulted from the introduction of antipsychotic and antidepressant medication in the fifties; psychiatric hospitals' intention to save dollars; public doubt and dissatisfaction with institutions; and a belief that mental illness is only a myth created by society to marginalize certain types of people (Mowbray & Holter, 2002). However, it has been exploiting families to provide unpaid labor to care for their family member with mental illness. Jones (1996) argues that mental health plans should provide reimbursement for the caregiving services in the home.

Recently introduced managed care, which has become the dominant plan for the privately insured, can be another example of a macrostructural factor that has changed the nature and organization of mental health care. Managed care emerged based on the assumption that "market forces bring efficiency, economy, and quality to public services" (Mowbray & Holter, 2002,

p. 145). Under managed care, federal and state funds for service costs are fixed per person, thereby minimizing the financial risk of the insurer (government) and shifting the cost burden to local government, service providers, and families. By fixing service costs, managed care has created an incentive for service providers to replace high-cost services with lower-cost services, such as community-based care. A major concern is that service providers may focus more on reducing costs rather than on meeting the needs of the families with a member with severe mental illness.

In sum, a macrostructual perspective presumes that macro-level social determinants are able to shape not only gender differences in caregiving behavior but also families' caregiving experiences of their family member with mental illness (Chesler & Parry, 2001; Cook et al., 1997; Risman, 1987).

Conceptual Model of Paternal Involvement in Caregiving Role

The basic conceptual model for this study is adapted from Risman's empirical model of parent-child interaction. Risman's (1987) empirical model contains components of individual-level, microstructural, and macrostructural factors but it is limited to include only a small number of variables. For example, the microstructural measure includes only one component, parental role (i.e., primary, shared, or breadwinner). Risman's empirical model is modified and enhanced in this study to show a more holistic picture of how various factors (i.e., individual-level, microstructural, and macrostructural level) in-

fluence fathers' participation in caregiving role. Key variables that have been identified to be, or are suspected to be, associated with the outcome of paternal caregiving are compiled and synthesized to construct the conceptual framework of this study (Fig. 2, p. 52). However, due to the lack of research findings on the fathers of offspring with mental illness, research evidence is adopted from various related studies, including fathers of offspring with mental retardation (Down's syndrome), physical illness (e.g., cancer), and physical disability.

The main idea underlying this conceptual framework is that paternal participation in the caregiving role is influenced by the combined work of individual-level, microstructural, and macrostructural factors. The purpose of this study is to examine relationships between paternal caregiving, and individual-level and microstructural factors. Therefore, this study limits its scope to examine only individualist and microstructural factors. It is beyond the purpose of this study to examine the influence of macrostructural factors, and therefore, it is only assumed in this study. It is hypothesized that each variable (i.e., individualist or microstructural level) included in this study will be associated with paternal caregiving outcome.

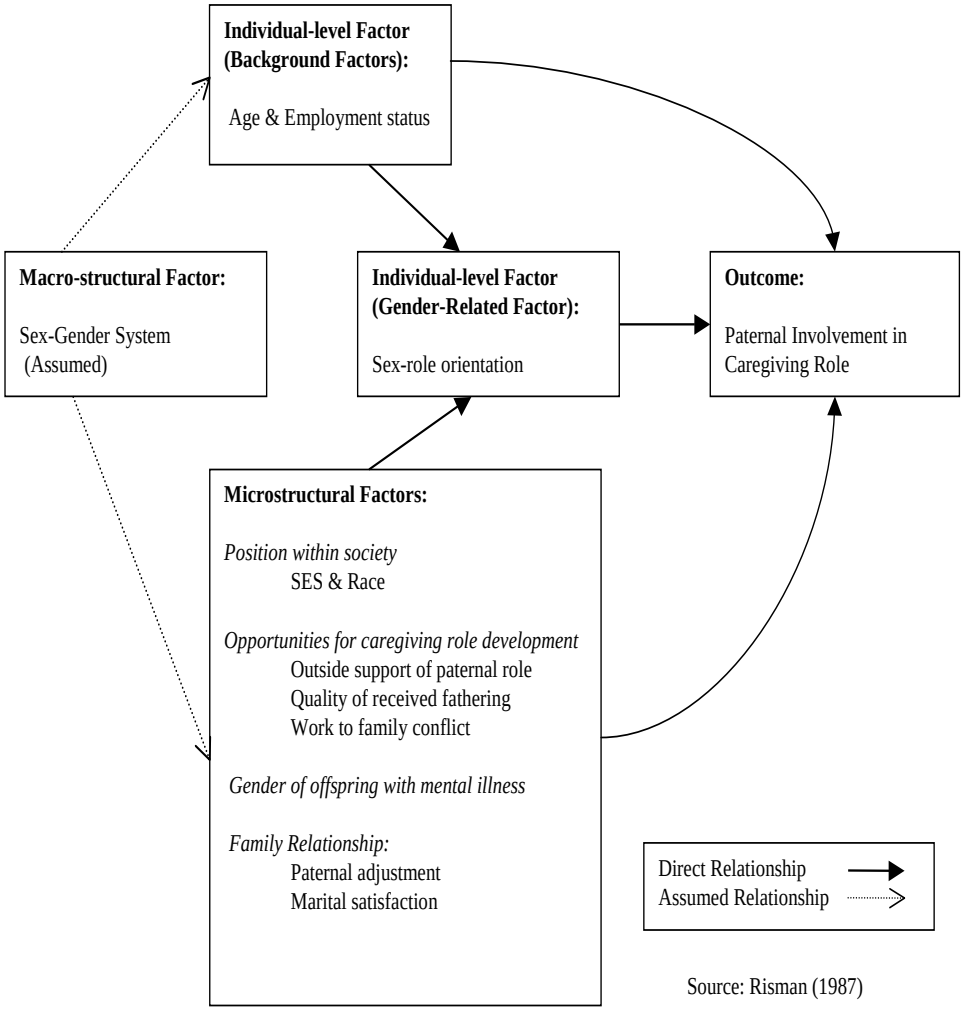

Figure 2: Conceptual Model of Paternal Involvement in Caregiving Role

Individual-level Measures

Gender-Related Factor

Sex-Role Orientation.

Sex-role orientation is "a product of historical, structural, cultural, and ideological forces that determine and reproduce socially constructed and shared understandings of what it means to be a man or a woman" (Chesler & Parry, 2001, p. 364). Gender goes through the iterative process of creation and re-creation in our social life, and is the "texture and order of that social life" (Lorber, 2003, p. 8). In his discussion of the paradoxes of gender, Lorber (2003) comments that gender is "so pervasive" in our society, we assume that it is "bred into our genes"; and "everyone does gender without thinking about it" (p. 8). Folk theories about sex differences also play a role in how individuals perceive and justify differences between men and women (Martin & Parker, 1995).

Internalized sex-orientation acquired from early socialization is very powerful and it shapes the nature and the degree of fathers' involvement with their offspring with mental illness and how they perform the caregiving role (Chesler & Parry, 2001). Traditionally, caregiving has been thought of as a feminine role in the society. Therefore, it is very plausible to hypothesize that the internalized sex-role orientation of fathers (e.g., masculine, feminine, or androgyny) may affect fathers' involvement in caregiving role (Fuller-Jonap & Haley, 1995; Segal, 1990). It is anticipated in this study that sex-role ori-

entation plays a significant role in either reducing or increasing the degree of fathers' participation in caregiving role. Fathers with a greater feminine orientation are expected to participate more in the caregiving role compared to fathers with more masculine orientation.

Microstructural Measures

Position within Society

Both SES and race have been commonly thought of as individual-level measures which define individual self. SES and race have been major social factors that people organize their lives by ascribing their membership in a category of people (Lorber, 2003). However, in this study, SES and race are perceived as microstructural measures reflecting an individual's position within society. In specific, SES and race are thought to generate differential exposure to structural barriers and opportunities to paternal caregiving. Harris and Morgan (1991) suggest that based on group membership, individuals identify "a set of norms and a set of parallel sanctions" (p. 532). Situation-specific role demands and support resources may differ based on an individual's SES and race, and therefore, these variables are perceived to condition the level of father involvement in caregiving role (Miller & Cafasso, 1992).

SES.

A small number of research findings are available that show how poverty

and welfare experiences influence the level of father involvement with their offspring (Dowd, 2000; Coley & Chase-Lansdale, 1999; Johnson, 1998b; Harris & Marmer, 1996). Based on the preliminary study findings, low-income fathers were less involved with their offspring both emotionally and behaviorally. For low-income fathers, affective, supportive, and nurturing aspects of fathering did not seem to have much meaning. On the contrary, low-income mothers were more likely to be emotionally attached to their offspring than mothers who were not low-income. As a consequence, the caring role imbalance between fathers and mothers is greater in low-income families. It is hypothesized in this study that the level of paternal participation in caregiving will reduce as the SES level declines.

Race.

Very little is known about how family caregiving experiences differ in relation to race. Although research findings on cultural contexts are very important for understanding the dimensions of caregiving experiences across various cultures, it did not gain adequate research attention.

In cultures that consider maternal caregiving as culturally appropriate and normative, caregivers are at elevated risk for depression. Mexican-American mothers who were taking care of their child with mental illness showed significantly higher levels of depressive symptoms relative to normative sample (Blacher et al., 1997). High levels of empathy and concern of caregivers may be associated with guilt and depression, burdened by the need

of their child that they care about (Chase-Lansdale et al., 1995). In Mexican culture, family cohesion (or "familisimo") is a key value that involves strong identification and attachment to nuclear and extended families. Familisimo can be a protective factor that reduces the risk for depression, but is believed to play a role in increasing the level of depression. If a Mexican-American mother does not receive help from other family members (because of her child with mental retardation), she will feel abandoned by her family, thereby increasing her level or risk of depression.

Similar to the Mexican American culture, African-American families are also known to consider caregiving a natural maternal role, and to emphasize family relationships that are nurturing, loving, and respectful. However, African-American mothers are generally believed to demonstrate greater resilience compared to other mothers from different cultures. Pruchno, Patrick, and Burant (1997) observed that, compared to White mothers of children with chronic disability, African-American mothers reported less caregiving burden and greater caregiving satisfaction despite having lower family income, having less education, being more likely to be unmarried, and being in poorer physical health. Researchers suggest that African-American mothers may have more caregiving satisfaction because most of them are living with their child with chronic disability and are able to provide more on-hands help to the child. However, Pruchno and colleagues caution that this resilient characteristc of African-American mothers (i.e., lower level of caregiving burden) should not be perpetrated to marginalize them from receiving "best practices" in service

provision.

It is very difficult to identify studies that explored how fathers across various cultures are experiencing caregiving. A small number of studies are available on African-American fathers. Johnson (1998b) observed African-American fathers and found out that they tended to define fatherthood in terms of their financial provider role success. As these fathers failed to fulfill their provider role, their overall participation in their families suffered. Coley and Chase-Lansdale (1999) also observed African-American fathers living in poor urban areas, and identified two dichotomous states of fatherhood: at one end there were highly involved and caring fathers, and at the other end, there were disengaged and out-of-touch fathers.

Due to the lack of previous research finding, no hypothesized relationship can be posed between race and paternal caregiving level.

Opportunities for Caregiving Role Development

Outside Support of Paternal Role.

It is generally supported that outside support (e.g., extended families, friends, colleagues at work, service providers) plays a key role in reducing burden and depressive symptoms in mothers of offspring with mental illness, suggesting the prominent role of social context for caregivers' psychological well-being. In a study by Greenberg, Seltzer, Krauss and Kim (1997), social support was a very important resource for mothers of adults with mental illness

to lower their burden and depressive symptoms. These mothers had small but intimate support networks which included at least one friend also caring for her child with mental illness.

Recent research findings also suggest that outside support of paternal roles may promote fathers' psychological well-being which may thereby increase their involvement in caregiving role (Chesler & Parry, 2001; Mcbride & Darragh, 1995). Einam and Cuskelly (2002) interviewed 12 fathers of a young adult with multiple physical or behavioral disabilities, and most of the fathers reported having "reduced support" and feeling "social isolation" due to their offspring's condition. If fathers receive necessary outside support in performing the caregiving role, they may be more willing to learn new skills and take on more caregiving responsibilities for their offspring with mental illness.

It is hypothesized that fathers will participate more in caregiving when the father is receiving stronger outside support for the paternal caregiving role.

Quality of Received Fathering.

The role of today's father has been passed down from the fathers of the preceding generation (Zoja, 2001). Starting from early childhood, sons learn and develop gendered personality structures and role orientations through their interactions with fathers (Lorber, 2003). According to Rossi (2001), adults with nurturant personalities are from parents who have high educational attainment, religious commitment, and capacity for generosity to others. These characteristics of parents open the way for children to become adults with

compassionate concern for others. Williams and Radin (1999) suggest that fathers' participation in caregiving has a long-term influence on sons' gender role attitudes. Their finding is supported by the social learning theory of Bandura (1986) that suggests the importance of same-sex role models for sons. According to Williams and Radin, sons learn gender roles by observing and imitating their fathers, and with fathers who are highly involved in caregiving, sons form a flexible gender role attitude roles.

A critical barrier to fathers assuming an active caregiving role may come from a lack of appropriate paternal role models. Different from women, men are not socialized to become fathers while they grow up and they may need to be provided with an adequate "learning process" to develop the paternal role (Mcbride & Darragh, 1995). Becoming a father is usually a thing that just happens to men (Kraemer, 1999; Furstenberg, 1995). In a relatively short time, the standard for being a good father has gone through generational changes. With the absence of a strong paternal role model to guide the role formulation, fathers are left in a position to create their own new models for fatherhood. Daly (1995) described this current state using the phrase, "being a model without a model" (p. 37). While doubt related to a good-father-role has heightened, fathers are likely to try seeking reference to appropriate paternal role models from previous generation, their fathers. According to Chesler and Parry (2001), "men's fathers" are "cultural models of fathering and maleness itself" (p. 373) and they state how men's own fathers could be seen as "role models and interpreters of the broader cultural frames of male-

ness and fathering" (p. 378). Therefore, fathers' perception of the quality of fathering (caregiving) they received from their own fathers as they grew up may influence fathers' current level of participation in caregiving for their offspring (Chase-Lansdale et al., 1995; Barnett & Baruch, 1987). Chase-Lansdale and colleagues (1995) suggest that a caring person results from the experience of growing up in a nurturing and caring relationship within the context of the family. Therefore, the father is expected to participate more in caregiving when the father has a greater degree of positive perception toward the quality of fathering he received.

Work to Family Conflict.

One of the serious barriers for father involvement is related to fathers' employment (Einam & Cuskelly, 2002; Sagi & Sharon, 1984). The social norms and support systems, the labor force structure, and the organization of social services all do not seem to encourage increased paternal involvement in caregiving for their offspring. Often, mothers are allowed to reduce work or make accommodations to care for their offspring with mental illness, but it is not the same for fathers. In 2004, the National Alliance for Caregiving conducted a national survey of 1,130 long-distance caregivers. Based on their study finding, women reported more missed hours of work per month due to caregiving (24 hours) than men (17 hours). Women were more likely than men to move from full-time to part-time work and to report they were considering leaving work ultimately. Unlike men, women were more likely to report that they were

the only or the main caregiver in the care situation, and were spending more time than men in helping the care recipient with personal care.

Gendered assumptions and norms underlying the social organization of employment provide fathers with less flexibility and fewer accommodations to take time off from work to care for their offspring. Barriers to fathers' active involvement in caregiving role may come from the threat of job loss, social disapproval, and social pressure to continue employment. As discussed previously in the literature review, historical public policies and systems of social provision have been deeply gendered and defined breadwinners are the only "correct form of fatherhood" (Hearn, 2002, p. 254). These barriers may in fact limit fathers' capacity to be supportive to their wives and to devote their energy or attention to the new family responsibility of caregiving for their offspring with mental illness (Chesler & Parry, 2001).

It is anticipated that fathers with lower degree of work-to-family conflict will participate more in caregiving role.

Gender of Offspring with mental illness

Research evidence suggests that the gender of offspring has a significant effect on either increasing or decreasing fathers' participation in caregiving (Williams & Radin, 1999; Harris et al., 1998; McConachie, 1982; Price-Bonham & Addison, 1978). For example, Price-Bonham and Addison (1978) suggested that fathers were more reluctant in accepting a son with mental ill-

ness than a daughter because "independence" is highly respected in American society. Similarly, Frey and colleagues (1989a) observed that fathers of sons with mental illness were more stressed and had more difficulty in making an adjustment. On the contrary, a more recent study by Rodrigue and associates (1992) suggested that fathers of sons with mental illness appeared to adjust better than fathers of daughters. Williams and Radin (1999) conducted a 20-year follow-up study of 50 intact, White, and middle-class families, and found out that as offsprings got older, fathers' involvement was more likely to be maintained at high level with sons than with daughters. Harris and associates (1998) also observed that fathers were more involved with sons than with daughters. Findings on how the father adapts to their sons or daughters with severe mental illness are inconsistent yet, but more recent research findings indicate that fathers get more involved with sons than with daughters.

In this study, it is anticipated that fathers will show increased level of participation in caregiving role when the person with mental illness is a son.

Family Relationships

Paternal Adjustment.

Based on previous research findings, fathers have more difficulties in making adjustments to their offspring with mental illness compared to mothers (Essex, 2002; Wintersteen & Rasmussen, 1997; Frey et al., 1989b; McConachie, 1982). According to Wintersteen and Rasmussen (1997), fathers

are more likely to participate in caregiving only after they have made adjustment to their offspring's mental illness. Paternal adjustment may be a key factor in determining the level of fathers' participation in caregiving role. It is expected in this study that the level of participation in caregiving will increase when the father is more adapted to the person with mental illness.

Marital Satisfaction.

Increased level of fathers' participation in caregiving role appears to be highly correlated with marital satisfaction (Essex, 2002; Harris et al., 1998; Harris & Marmer, 1996; Mcbride & Darragh, 1995). In a happy marriage, a father will be encouraged to fulfill his wife's expectation, and caring for their offspring is a part of the husband's role. For the father, participating in caregiving will be more enjoyable because he is sharing the same experience with his wife. Performing this caring role well will give satisfaction to the father himself and his wife, and it will promote marital satisfaction (Harris & Morgan, 1991).

According to Barnett and Baruch (1987), level of participation may not be necessarily related to the demands that their offspring with mental illness put on them. When marital satisfaction is low, fathers are likely to disengage themselves from their offspring in both behavioral and emotional ways whereas mothers are likely to become more involved with their offspring (Essex, 2002; Harris et al., 1998). Harris and Marmer (1996) suggest that in happy marriages, mothers' encouragement is very successful in increasing fa-

thers' participation in the caregiving role.

Despite the common belief, Hornby (1995) suggested that marital conflict did not result from the presence of offspring with mental illness. McAndrew (1976) found out that having a child with disability often strengthened a marital relationship at least early in the child's life. In this particular study (McAndrew, 1976), if parents were experiencing marital problem, the conflict between the parents often had developed before the birth of their child. However, Roesel and Lawlis (1983) identified a high probability of risk for divorce, when the parents were young or it was their first-born child who had mental retardation.

Based on the research findings, it is hypothesized in this study that fathers will participate more in caregiving when the father is more satisfied with his marriage.

CHAPTER 4 METHOD

Sample

A total of 104 fathers of offspring with mental illness were recruited through public mental health organizations in Austin, Texas, mental health conferences, and via internet survey. They were asked to answer a survey questionnaire related to their caregiving experiences.

Sources of study participants were Austin Travis County Mental Health and Mental Retardation Center, Mental Health Association of Austin, Austin State Hospital, National Alliance for the Mentally Ill (NAMI) of Austin, Planned Action Network (PLAN) of Austin, and the African American Family Support Network of Austin. Additional participants were recruited in 4 mental health conferences including: 4th annual Bexar County Consumer and Family Support conference (San Antonio, TX), 2004 NAMI National Convention (Washington D.C.), 2004 NAMI Texas convention (San Antonio, TX), and 5th annual Central Texas African American Family Support conference (Austin, TX). Data collection period was from December, 2003 to February,

2005.

Table 1 (p. 67–68) outlines the demographic and socio-economic characteristics of the 104 fathers participated in this study. The age of fathers ranged from 33 to 81 years with a mean of 56 years ($SD = 11.34$). The majority of fathers were Anglo-American (76%), and other race/ethnicity included 5.8% African-American, 12.5% Mexican-American, 1.0% Asian-American, 2.9% Native-American, and 1.9% other. At the time of the inquiry, 67.3% of all fathers were employed, and 86% of fathers were married. Many fathers were living with their offspring to provide family care (73.1%). Fathers who participated in this study were mostly from middle to upper socio-economic backgrounds. College graduated fathers comprised the largest group (37.9%), and 16.3% of all fathers had graduate degrees. Almost half of the fathers (48.1%) reported annual household income of $50,000 and more, and the median annual household income (category) was $35,000-$49,000. Of offspring with severe mental illness, 63.5% were sons, and their age ranged from 2 to 50 years, with a mean of 24.93 years ($SD = 9.77$).

Procedure

The recruitment of 104 fathers of offspring with mental illness was done in combination of both paper-and-pencil survey and online survey in order to maximize the chance to approach the target population.

Table 1: Demographic and Socio-Economic Statistics of Study Participants

Demographic Characteristics	
Fathers' age	
30–49	20.2%
50–59	47.1%
60–69	20.2%
70–79	9.6%
80 and over	1.0%
Race/Ethnicity	
Anglo-American	76.0%
African-American	5.8%
Mexican-American	12.5%
Asian-American	1.0%
Native-American	2.9%
Other	1.9%
Father's employment status (% employed)	67.3%
Marital status	
Single	1.9%
Widowed	3.8%
Divorced	7.7%
Married/Long-term partner	86.5%
Residential status (% living with offspring)	73.1%

(table continues)

Table 1: Demographic and Socio-Economic Statistics of Study Participants *(Cont.)*

Socio-Economic Variables	
Fathers' education level	
Less than high school	8.7%
High school graduate	14.4%
Some college/vocational school	21.2%
College graduate	39.4%
Graduate school graduate	16.3%
Family income (per year)	
$10,000 $24,999	16.3%
$25,000 $49,999	35.6%
$50,000 $99,999	30.8%
$100,000 and over	17.3%
Offspring Characteristics	
Gender (% male)	63.5%
Age	
1-9	2.9%
10-19	28.8%
20-29	40.4%
30-39	19.2%
40-50	8.7%

It was anticipated that recruiting participants through paper-and-pencil survey only would be extremely difficult. Fathers of offspring with mental illness are a population that is very difficult to identify or approach. In addition, males are generally known as a difficult group to get consent from to participate in a research study. Moreover, only few devoted fathers attend mental health conferences or meetings due to their personal, emotional, or occupational reasons; therefore, it is almost impossible to gather participants at one place at a specific time to administer a paper-and-pencil survey. An online survey was utilized as a supplement method to reduce aforementioned limitations posed by the paper-and-pencil survey. The online survey was expected to minimize fathers' reluctance to participate in the study by ensuring privacy, since participants would not be identified by others as respondents to a research study.

Paper-and-pencil Survey

Fathers of offspring with mental illness were recruited through targeted advertisements using invitation letters, regular monthly newsletters, or e-mails of aforementioned sources. The chair of the respective organizations described the study to their members and invited them to participate in the study. Other potential participants were asked to participate in the study when they attended public conferences or regular monthly meetings of their organizations. The chair of the respective organizations described the study to their members

and referred those that had an interest to the researcher. The researcher attended each of those meetings and described and discussed the study in detail with fathers who expressed an interest in participation. Fathers were asked to complete the survey questionnaire individually and return it back to the researcher at a convenient time. If desired, participants were given the option to return the survey questionnaire with the provided return envelope.

At the time that a father expressed an interest or willingness to participate in the study, a consent form was provided. The individuals had the opportunity to read the informed consent forms for themselves and ask questions to the researcher. Once the participant indicated that he understood the consent form and had exhausted his questions, he was asked to sign the forms. Participants were informed that their participation was both voluntary and confidential, and refusing to participate in the study would not harm their current and future relationship with the mental health center, state hospital, the voluntary organization or the University of Texas at Austin. The participants were advised they could decide at this or any other point to withdraw from participation. Once signed and collected, consent forms were kept separately from the questionnaire, and the information remained confidential.

Online Survey

The invitation letters, newsletters, or e-mails to potential participants carried a hyperlink to a Web site containing the survey. Information about

the online survey was also disseminated to potential participants at related mental health conferences and meetings. Participants who were interested in the study and preferred online survey over the paper-and-pencil survey were asked to go online to the Web site. Intended participants independently needed to obtain access to a computer with internet service either at the conference location (i.e., complimentary internet cafe for conference participants) or at their private places.

As this study recruited participants through targeted advertising through invitation letters and newsletters of mental health organizations, it is very unlikely that non-target populations will participate in this study while surfing the internet. However, as an effort to control participation, it will be clearly stated in the Web survey introduction and instructions that the study is specifically designed for fathers who have children with severe mental illness.

Contents of the Web site included a brief introductory letter, the informed consent page and the Web survey. Participants were provided with the opportunity to read the consent page online at their most convenient time and in the place where they felt most comfortable and safe.

The consent page included Q & As (questions and answers) that address anticipated questions and concerns of potential participants. Although the researcher would not be physically present with individual participants during the informed consent process, a phone number and e-mail address of the researcher were provided on the consent form for the participants to communicate any concerns or questions. In addition, the participants were able to

get a hard copy of their consent form by printing it.

After reading the consent, those who wished to continue with the study were asked to click on a button saying "I agree" and begin to self-administer the survey. The Web survey was expected to take 30 minutes for the participants to complete. To prevent missing data, a computer response appeared when an answer was not provided on the survey (i.e., "Missing Values: The following field(s) require values before the record can be added: Paternal Involvement / Item 10, Marital Satisfaction / Item 1"). Once the survey was accepted as complete, the data was automatically downloaded into a database and a numerically sequential participant ID (identification) number was automatically generated for the participant response.

Benefits of the Online Survey

Recent research evidence suggests that data provided by Internet methods are equivalent to those provided by paper-and-pencil methods in terms of quality and reliability. Findings from Internet methods are consistent with those findings from paper-and-pencil methods. Internet samples are also proven to have relative diversity in socioeconomic status, geographic region, and age (Gosling et al., 2004).

Web survey is now preferred for several reasons. Four related benefits are noted in the literature. First, it has greater potential to recruit the targeted number of participants (Riva et al., 2003; Eaton & Struthers, 2002; Fricker

Jr. & Schonlau, 2002; Montgomery, 2002). The use of internet can make the target population more accessible to the researchers. Potential respondents can participate in the study at any time, at their convenient places, because the internet survey tool can be provided around the clock, with no time limitation.

Second, the internet survey has a benefit for protecting participant privacy (Barry, 2001; Eysenbach & E.Till, 2001; Riva, 2001). As this study involves a sensitive issue regarding offspring's mental health, potential participants may feel uncomfortable to meet with other people (i.e., the researcher and other study participants). The internet survey can provide better protection for participants by minimizing the risk for being exposed as a study subject. Participants will have the opportunity to read the consent page online, at their most convenient time and in the place where they feel most comfortable and safe. Respondents may feel encouraged to respond more honestly because of this confidentiality safeguard.

Third, the internet survey has a benefit for providing greater participant freedom to withdraw (Riva et al., 2003; Nosek et al., 2002). Due to the physical absence of a researcher, participants do not need to engage in face-to-face interaction with the researcher, which assures participant anonymity. It also removes implicit situational pressures on the participants, such as politeness norms. For instance, participants do not have to feel situational demands to continue answering the survey if they feel it is too uncomfortable or unrewarding. Participants could easily discontinue their participation at any time. In fact, findings from the literature report that the "completely voluntary par-

ticipation" of respondents would increase respondents' motivation to answer survey questions.

And finally, the internet survey has a benefit in avoiding data entry error (Fricker Jr. & Schonlau, 2002; Liaw, 2002; Nosek et al., 2002). In Web surveys, respondents' answers will be directly downloaded into a database, which saves time for the researcher and also removes the concern for data entry error.

Predictor Variables

Definition of all variables in this study is summarized in Table 2 (p. 81 – p. 84).

Individual-level Measures

Age and Employment Status of Fathers

Age of fathers (in years) and employment status of fathers (1=employed, 2=unemployed) were measured. These variables are control variables in this study.

Sex-Role Orientation

The Bem Sex-Role Inventory Short Form (BSRI) (Bem, 1978) was used to access the sex role orientation of fathers as either masculine, feminine, an-

drogynous, or undifferentiated. The BSRI contains 10 adjectives related to masculine personality characteristics, 10 adjectives related to feminine personality characteristics, and 10 adjectives related to androgynous personality characteristics. Fathers were asked to rate how well each adjective described them on a 7-point scale ranging from "1=never or almost never true of me" to "7=always or almost always true of me."

For the purpose of data analysis, Femininity minus Masculinity Difference score was computed based on fathers' scores on the Short BSRI. One of our study hypothesis is that fathers with more feminine characteristics will participate more in caregiving role. High positive scores on the Femininity minus Masculinity Difference score indicate a tendency to be strongly feminine, and high negative scores indicate strong masculinity.

The Short BSRI is an equivalent test to the Original BSRI (60 items), only with fewer items(30 itmes) for easier administration and scoring. The Short BSRI has high level of internal consistency reported by the author, with the coefficient alpha over .75. It is also proved to be highly reliable: the lowest test-retest reliability reported was .76 (Bem, 1978).

Microstructural Measures

Socio-Economic Status (SES)

Average annual household income (range from "1=$0 - $4,999" to "9=$100,000 and over") and father's highest educational level achieved (range from "1=less

than 9th grade" to "5=doctoral degree") were used to measure SES level.

Race/Ethnicity

Fathers were asked to provide information about their race/ethinicity (e.g, Anglo-American, African-American, Mexican-American).

Work to Family Conflict

The Work-Family (WF) scale from the Work-Family and Family-Work Conflict Scales (WF/FWCS) (Netemeyer et al., 1996) was used to measure difficulties experienced at home caused by work demands (work-to-family conflict). The WF scale is a 5-item scale responded to on a 7-point scale ranging from "1=strongly disagree" to "7=strongly agree." Sample items include, "The demands of my work interfere with my home and family life" and "My job produces strain that makes it difficult to fulfill family duties." Higher scores indicate greater levels of work to family conflict. Alpha for the WF/FWCS scale ranged from .82 to .90 (Netemeyer et al., 1996).

Quality of Received Fathering

Fathers were asked about the quality of fathering (caregiving) experience they received from their fathers using 3 items: (1) How would you rate the quality of fathering (caregiving) experience that you received from your

father while you were growing up?; (2) How positive a role did your father play in your life?; and (3) How available was your father for you? The result will be reported on a 7-point scale ranging from "1=very negative (or very unavailable)" to "7= very positive (or very available)."

Outside Support of paternal role

The overall degree to which fathers feel supported from others outside the family in performing the father role will be measured using 3 items: (1) Overall, what is the level of support you get from your extended family members in performing the father role?; (2) Overall, what is the level of support you get from extra-familial members in performing the father role? (e.g., friends, neighbors, church, colleagues at work, etc.); and (3) Overall, what is the level of support you get from institutional resources in performing the father role? (e.g., daycare center, hospital, mental health service agencies, etc.) The result will be reported on a 7-point scale ranging from "1=very unsupportive" to "7=very supportive."

Gender of offspring with mental illness

Gender (1=male, 2=female) of offspring was asked. At the beginning of the survey, it was specified that the father who had more than one offspring with mental illness should answer the questions according to his offspring with the most severe mental illness.

Paternal Adjustment

The overall degree to which fathers feel adjusted to their offspring's mental illness was measured by a 2-item Likert-type scale. Items were adapted from the Single Parent Adjustment Scale (SPAS) (Singh & McBroom, 1992) and were modified in order to measure the degree of paternal adjustment in this study. These modified items were reviewed by the original authors and were approved for use. The SPAS has subcategories including conformity and satisfaction. Items were taken out of each of these categories and they included, "How well do you think you are able to meet needs of your child?" ("1=fail to meet needs" to "4=adequately, with no problems") and "How do you presently feel about being around your child?" ("1=feel miserable" to "5=love it"). The score ranges from 2 to 9, with higher scores indicating more paternal adjustment.

Marital Satisfaction

The 3-item Kansas Marital Satisfaction (KMS) (Schumm et al., 1986) scale was used to measure the degree of marital satisfaction on the father's part. Sample items include, "How satisfied are you with your marriage?" and "How satisfied are you with your relationship with your wife?" Items are responded on a 7-point scale ("1=extremely dissatisfied" to "7=extremely satisfied"). The possible score ranges are from 3 to 21 and higher scores reflect greater marital satisfaction. Single, widowed, or divorced fathers were given

the option to indicate on the scale that they were not married ("8=currently, not married"), and they were coded as missing. Authors report the Alpha of .93 and excellent concurrent validity with the Quality of Marriage Index.

Outcome Variable

Paternal Involvement in Caregiving

A Paternal Involvement in Caregiving scale was developed for the purpose of this study and was administered to measure the amount of paternal involvement in caregiving role. Based on the basic framework of the Paternal Involvement and Child Care Index (PICCI) (Radin, 1981), and based on the related literature review, items were adopted and developed to capture the paternal caregiving involvement with offspring (regardless of age). The scale includes 17 items and they access the level of paternal participation in four areas: (1) involvement in caregiving, (2) care responsibilities, (3) influence in decision making, and (4) availability. The format of the scale includes a Likert-type scale. The score ranges from 16 to 74, with higher scoring on this scale indicating a higher level of paternal involvement.

Personal Background Variables

Information on personal background was obtained: father's age, employment status, marital status, education level, annual household income, residence status of offspring (with mental illness), age of offspring, gender of offspring, and overt affection level to offspring.

Fathers' overt affection to their offspring was measured by a 3-item Likert-type scale. Items were adapted from the Parent-Child Closeness (PCC) (Buchanan et al., 1991) scale and were modified to fit the purpose of this study. These modified items were reviewed and approved by the original authors. Sample items include, "How often do you express affection or liking for your offspring?" and "How close do you feel to your offspring?" Response range from this scale were made on a 5-point scale ranging from "1=not at all" to "5=very." The score ranges from 3 to 15, with higher scores indicating more affection to the child.

Table 2: Summary: Definition of Variables

Variable	**Definition**
Individual-level Variables	
Background Factors:	
Father's age	Continuous score indicating father's age (in years)
Father's employment status (ref.: Unemployed)	Father employed=1, otherwise=0
Gender-related Factor:	
Father's femininity level	Femininity minus Masculinity Difference score of fathers computed based on father's score on the Bem Sex-Role Inventory short form (Bem, 1978): (Score range: -82 to 69, Higher score closer to 69 indicates greater level of femininity)
Microstructural Variables	
Position within Society:	
SES	Sum score of both (a) Education and (b) Annual family income. (Score range: 2–16, Higher score indicates higher level of SES)
a. Education	Less than 9th grade=1 9th to 12th grade. No completion=2 High school graduate or completed GED=3 Some college. No degree=4 College graduate=5 Master's degree=6 Doctoral degree=7

(table continues)

Table 2: Summary: Definition of Variables *(Cont.)*

Variable	**Definition**
b. Annual family income	$0 – $4,999=1 $5,000 – $9,999=2 $10,000 – $14,999=3 $15,000 – $24,999=4 $25,000 – $34,999=5 $35,000 – $49,999=6 $50,000 – $74,999=7 $75,000 – $99,999=8 $100,000 and over=9
Race (ref.: White)	Non-White=1, otherwise=0
Opportunities for Caregiving Role Development:	
Quality of received fathering	Continuous score indicating father's score on items related to the quality of fathering (caregiving) experience that he received from his father. (Score range: 3 to 21, Higher score indicates higher level of the quality of received fathering.)
Outside support of paternal role	Continuous score indicating father's score on items related to the level support that he received from outside sources in performing the father role. (Score range: 3 to 21, Higher score indicates higher level of the outside support.)
Work-to-family conflict	Continuous score indicating father's score on the Work-Family (WF) scale (Netemeyer et al., 1996) (Score range: 5 to 35, Higher score indicates higher level of work-to-family conflict.)

(table continues)

Table 2: Summary: Definition of Variables *(Cont.)*

Variable	**Definition**
Gender of the Offspring with mental illness: (ref.: Male offspring)	Female offspring=1, otherwise=0
Family Relationships:	
Paternal adjustment	Continuous score indicating father's score on items related to the level support that he received from outside sources in performing the father role. (Score range: 2 to 9, Higher score indicates higher level of the outside support.)
Marital satisfaction	Continuous score indicating father's score on the Kansas Marital Satisfaction (KMS) scale (Schumm et al., 1986) (Score range: 5 to 35, Higher score indicates higher level of work-to-family conflict.)
Personal Background Variables	
Age of offspring:	Continuous score indicating offspring's age (in years)
Father's marital status:	Single=1 Widowed=2 Divorced=3 Married/Long-term partner=4
Living with offspring?:	Yes=1, No=2
Overt affection to offspring	Continuous score indicating father's score on items related to his level affection to offspring. (Score range: 3 to 15, Higher score indicates higher level of affection.)

(table continues)

Table 2: Summary: Definition of Variables *(Cont.)*

Variable	**Definition**
Dependent Variable	
Paternal involvement in caregiving	Continuous score indicating father's score on items related to his level of caregiving involvement (Score range: 16 to 74, Higher score indicates greater level of caregiving involvement.)

Plan for Analysis of Results

Independent sample t-test was used to examine the differences in demographic, socio-economic characteristics, and outcome variable (i.e., paternal involvement in caregiving) between groups of fathers who responded to paper-and-pencil survey and groups of fathers who participated in the Internet survey. Married fathers and unmarried fathers were compared on the level of paternal involvement in caregiving and on *opportunities for caregiving role development* using the independent sample t-test. Differences in paternal involvement, socio-economic and microstructural characteristics between Anglo-American fathers and fathers from diverse culture were also examined using the independent sample t-test. One-way analysis of variance (ANOVA) was used to examine differences of paternal involvement between four groups of fathers with masculine, feminine, androgynous, or undifferentiated sex-role

orientation.

Hierarchical multiple regression was used to analyze differential effects of individual and microstructural factors on paternal caregiving involvement (Table 3, p. 86). To control for father's age and employment status, these variables were entered first as a block. *Gender-related factor* (i.e., sex-role orientation) was entered as a second block. The third block included *position within society*, comprising SES and race. The fourth block included *opportunities for caregiving role development*, including work-to-family conflict, quality of received fathering, and outside support of paternal role. The fifth block included *gender of offspring with mental illness*. Finally, the sixth block included *family relationships*, consisting of paternal adjustment, and marital satisfaction. Interaction effects were also examined to see how marital status (moderator variable) moderates the relationship between study variables and the outcome variable.

Table 3: Hierarchical Regression Models

Variable
Individual-level Measures
Step 1 *Background Factors:*
Father's age
Employment status
Step 2 *Gender-related Factor:*
Sex-role orientation
Microstructural Measures
Step 3 *Position within Society:*
SES
Race
Step 4 *Opportunities for Caregiving Role Development:*
Quality of received fathering
Outside support of paternal role
Work to family conflict
Step 5 *Gender of Offspring with mental illness*
Step 6 *Family Relationships:*
Paternal adjustment
Marital satisfaction

CHAPTER 5 RESULTS

Descriptive Analyses

Table 4 (p. 88) shows the comparisons of paper-and-pencil survey participants and internet survey participants on the demographic, socio-economic, and outcome variables (i.e., paternal involvement in caregiving). Among the study participants, 30.8% of fathers responded through paper-and-pencil survey questionnaire, and 69.2% of them responded via internet. One of the major limitations of an internet survey is that it poses potential risk for coverage error (Riva et al., 2003; Liaw, 2002; McFarlane et al., 2002; Barry, 2001; Lenert et al., 2002). Respondents who can and will participate in a Web survey are more likely to have high levels of access to the Internet and are often people with higher SES levels. Therefore, internet samples are likely to underrepresent populations with low SES levels. As more than half (69.2%) of our study participants responded through internet, we examined the differences between two groups of fathers (i.e., paper-and-pencil survey respondents and internet survey participants) on demographic, socio-economic, and outcome variables.

Table 4: Comparisons of Paper-and-pencil Survey Participants and Internet Survey Participants on Demographic, Socio-Economic, and Outcome Variables

	Mail		**Internet**		
Variable	Mean	SD	Mean	SD	t
Father's age	60.41	8.50	54.04	11.93	2.723*
Race/Ethnicity	1.69	1.09	1.49	1.16	ns
Father employment	1.34	.48	1.32	.47	ns
Annual household income	6.28	1.92	6.46	1.64	ns
Father's education level	4.09	1.53	4.49	1.13	ns
Paternal involvement in caregiving	47.03	13.20	45.38	11.33	ns

Note. $^{*}p < .01$

Contrary to our presumption, there was no significant difference in terms of socio-economic factors and outcome variable between paper-and-pencil survey participants and internet survey participants. There was no differences in terms of race/ethnicity, father's employment status, annual household income, father's educational level, and levels of paternal involvement in caregiving. Socio-economic differences may not have become an issue with our sample because most of our study participants already belong to the middle to upper level of SES. The only significant difference between the two groups of fathers was age, $t(102) = 2.723, p < .01$. Fathers who used internet survey were younger in age with a mean age of 54.04 years ($SD = 11.93$) whereas the mean age of mail survey respondents was 60.41 years ($SD = 8.50$). This is understandable knowing that younger persons are more comfortable with

using modern technologies than older generations. The internet survey seemed to be preferred by our study participants because of its convenience and ease of use. When recruiting potential participants at various conferences, many fathers expressed preference for the internet survey because they could do it at their work when they took a break. More than half of fathers (67.3%) in our sample are employed, and the internet survey may have fit well with their schedule than the paper-and-pencil survey.

As there was no significant difference between paper-and-pencil survey participants and internet survey participants, they were collapsed into one sample for data analysis.

Intercorrelations among study variables are presented in Table 5 (p. 90). Paternal Involvement in Caregiving was highly correlated with Father's Level of Femininity, $r(102) = .546, p < .001$, and Paternal Adjustment, $r(102) = .557, p < .001$. Paternal Adjustment and Father's level of Femininity were strongly correlated with each other, $r(102) = .615, p < .001$.

Table 6 (p. 91) shows the level of paternal involvement in caregiving reported by our study participants. Fathers who showed interest and participated in this study were more likely the fathers who were involved in caregiving of their offspring with mental illness. More than half of the fathers (76%) reported that they were "very involved" or "involved" in the caregiving role. But as expected, more than half of the fathers reported their spouse as the primary caregivers of their offspring with severe mental illness (64.4%). About 22% of these fathers described themselves as the primary caregivers, however 13.5%

Table 5: Intercorrelations among Study Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Paternal involvement in caregiving	-											
2. Fathers' age	.017	-										
3. Father employed	-.067	-.405***	-									
4. Father's level of feminity	.546***	-.070	.104	-								
5. Socio-Economic Status	.126	.053	.336***	-.242**	-							
6. Non-White	-.033	-.034	-.088	.065	-.445***	-						
7. Quality of received fathering	-.248**	.027	.156	-.408***	.120	.071	-					
8. Outside support of paternal role	.230**	.223*	.020	.399***	.036	-.088	-.243**	-				
9. Work-to-family conflict	.297**	.148	-.132	.418***	-.044	-.038	-.328***	.486***	-			
10. Female offspring	-.102	.133	.018	.175*	.050	-.053	-.042	.242***	.217*	-		
11. Paternal adjustment	.557***	-.074	-.210*	.615***	-.273**	.245**	-.442***	.303**	.401***	.010	-	
12. Marital satisfaction	.135	.107	.029	.357***	.037	-.063	-.256**	.416***	.262**	-.053	.414***	-

Note. $^{*}p < .05$ $^{**}p < .01$ $^{***}p < .001$

Table 6: Paternal Involvement in Caregiving reported by Fathers

Variable	
Paternal Involvement in Caregiving	
Primary caregiver of offspring	
Father	22.1%
Mother	64.4%
Other	13.5%
Caregiving Involvement	
Very Involved	37.5%
Involved	38.5%
Neutral	11.5%
Uninvolved	4.8%
Very Uninvolved	7.7%
Financial support	
Very Involved	39.4%
Involved	43.3%
Neutral	2.9%
Uninvolved	2.9%
Very Uninvolved	11.5%
Emotional support	
Very Involved	34.6%
Involved	33.7%
Neutral	23.1%
Uninvolved	2.9%
Very Uninvolved	5.8%
Care responsibility	
Father more	9.6%
Shared	53.8%
Mother more	36.5%
Influence in decision making	
Father more	13.5%
Shared	48.1%
Mother more	38.5%
Availability	
Available	53.8%
Sometimes	36.5%
Unavailable	9.6%

of fathers reported that their offspring was receiving primary care from other sources (i.e., mental health services). The majority of fathers assumed great responsibility in providing financial support to their offspring. Fully 82.7% of fathers were involved in the provider role. More than one-half of fathers (68.3%) were involved in providing emotional support to their offspring. For care responsibility, 53.8% of fathers reported they were sharing care-related tasks with their spouse, for example: helping the offspring with daily chores, helping the offspring with personal problems; taking the offspring to doctor's or hospital appointments. Only 9.6% of fathers reported having primary responsibility in care-related tasks, and 36.5% of fathers reported having low level of responsibility in such tasks. When making decisions related to their offspring's education, future care or medical treatment and care, 48.1% of fathers reported equally sharing the responsibility with their spouse: 13.5% of fathers assumed primary responsibility in decision making, and 38.5% of fathers reported that their spouses mainly made such decisions. About one-half of fathers (53.8%) reported that they were available to their offspring most of the time, while 36.5% reported being available sometimes, and 9.6% of fathers reported being unavailable.

Table 7 (p. 93) shows father's sex-role orientation. The largest proportion of fathers (50%) had androgynous sex-role orientation, and fathers with feminine sex-role orientation comprised the smallest group (6.3%). Using a One-way analysis of variance (ANOVA), we examined differences in the level of caregiving involvement between four groups of fathers with different sex-

Table 7: Sex-Role Orientation of Fathers

Variable	
Sex-Role Orientation	
Undifferentiated	17.3%
Masculine	16.3%
Feminine	6.3%
Androgynous	50.0%

role orientations. Fathers' sex-role orientation did not have a strong influence on paternal caregiving role involvement, $F(3, 90) = 2.55, p = .061$. Sex-role orientation of fathers only explained 8% of variances in paternal involvement in caregiving.

Table 8 (p. 94) outlines factors that provide opportunities for caregiving role development of fathers including, outside support of paternal role, quality of received fathering (caregiving), and work-to-family conflict. About half of all fathers stated that they were receiving moderate level of outside support from extended families (50%), extra-families (53.8%) (e.g., friends, church members, colleagues at work), and institutions (44.2%) (e.g., mental health organizations).

About half of all fathers (54.8%) reported that the quality of fathering (caregiving) they received from their fathers when growing up was either "very positive" or "positive." Contrary to our presumptions, only 15.4% of fathers

Table 8: Opportunities for Caregiving Role Development of Fathers

Variable	
Outside Support of Paternal Role	
Extended family support	
High	39.4%
Moderate	50.0%
Low	10.6%
Extra-familial support	
High	33.7%
Moderate	53.8%
Low	12.5%
Institutional support	
High	32.7%
Moderate	44.2%
Low	23.1%
Quality of Received Fathering	
Positive	54.8%
Neutral	26.0%
Negative	19.2%
Work-to-Family conflict	
High	15.4%
Moderate	18.3%
Low	66.3%

agreed that their job made it diffcult for them to fulfill family responsibilities. More than half of fathers (66.3%) reported low level of conflict between their job and their family life.

Table 9 (p. 95) shows family relationships reported by fathers in our sample. Fully 27.9% of fathers indicated that they "love" or "enjoy" being around their offspring and they had little or no difficulty in meeting needs of their offspring. More than half of fathers (59.6%) reported they were moderately adjusted to their offspring with mental illness, and 12.5% of fathers indicated they felt "miserable" or "stressed" being around their offspring and were failing to meet their needs.

Table 9: Family Relationships reported by Fathers

Variable	
Father Adjustment	
High	27.9%
Moderate	59.6%
Low	12.5%
Marital Satisfaction	
Satisfied	62.5%
Neutral	17.3%
Dissatisfied	6.7%
Overt Affection to Offspring	
Strong	69.2%
Moderate	21.2%
Weak	9.6%

More than half of fathers (62.5%) reported their satisfaction with their marriage, and 69.2% of all fathers indicated having strong affectionate and intimate feelings toward their offspring with mental illness.

Using an independent sample t-test (Table 10, p. 97), married fathers are compared to unmarried fathers (i.e., single, widowed, divorced fathers) on Opportunities for Caregiving Role Development and outcome variable. There was a significant difference between these two groups in terms of outside support of paternal role, and quality of receive fathering. Married fathers were receiving a greater degree of overall outside support ($M = 14.42, SD = 4.31$) than unmarried fathers ($M = 10.93, SD = 5.51$), $t(102) = -2.72, p < .01$. Specifically, married fathers were receiving a greater level of support from their extended families ($t(102) = -2.31, p < .05$), and mental health related institutions ($t(102) = -3.76, p < .001$). Substantial mean difference existed in terms of the quality of fathering received: married fathers reported more positive experiences with their own fathers ($M = 14.67, SD = 5.24$) than unmarried fathers ($M = 8.50, SD = 5.40$), $t(102) = -4.08, p < .001$. There was no significant difference among the two groups of fathers in work-to-family conflict and the level of involvement in caregiving.

Table 10: Comparisons of Married Fathers and Unmarried Fathers on Opportunities for Caregiving Role Development and Outcome Variable

	Married		**Unmarried**		
Variable	Mean	SD	Mean	SD	*t*
Outside Support of Paternal Role	14.42	4.31	10.93	5.51	-2.72**
Extended family support	5.03	1.58	3.93	2.13	-2.31*
Extra-familial support	4.76	1.62	4.36	2.21	ns
Institutional support	4.63	1.76	2.64	2.34	-3.76***
Quality of Received Fathering	14.67	5.24	8.50	5.40	-4.08***
Work-to-Family Conflict	14.18	9.09	14.64	10.51	ns
Paternal Involvement in Caregiving	45.06	10.22	51.21	19.28	ns

Note. Greater scores indicate greater or increased level of each variable attribute.
$^{*}p < .05$ $^{**}p < .01$ $^{***}p < .001$.

Table 11 (p. 99) shows the result of an independent sample t-test, comparing Anglo-American fathers with fathers from diverse cultures. As expected, Anglo-American fathers had significantly higher SES levels than fathers from diverse cultures, $t(102) = -5.02, p < .001$.

Father adjustment was a significant factor distinguishing Anglo-American fathers, and fathers from diverse cultures, $t(102) = 2.55, p < .05$. Compared to Anglo-American fathers ($M = 6.22, SD = 1.61$), fathers from diverse culture had a greater degree of adjustment to their offspring with mental illness ($M = 7.20, SD = 1.91$). One of the interesting findings in this study was the resilience of fathers from diverse cultures. Parents with lower SES are more likely to experience psychological distress, to have poor physical health, and to have limited access to health care and formal services (Chase-Lansdale et al., 1995). Regardless of their limited resources, fathers from diverse cultures were more adjusted to their offspring with mental illness. Resilience of families from diverse cultures is noted in previous research (Pruchno et al., 1997). There was no difference between Anglo-American fathers and fathers from diverse cultures in terms of opportunities for caregiving role development, marital status, marital satisfaction, level of overt affection to offspring, and the residential status of offspring.

Table 11: Comparisons of Anglo-American Fathers and Fathers from Diverse Cultures on Outcome Variable and Study Variables

	Anglo-Americans		Diverse Culture		
Variable	Mean	SD	Mean	SD	*t*
Paternal Involvement in Caregiving	46.10	11.65	45.20	12.87	ns
Primary caregiver [a]	1.91	.57	1.93	.73	ns
Overall caregiving	3.97	1.09	3.80	1.44	ns
Financial support	3.93	1.24	4.14	1.41	ns
Emotional support	3.86	1.01	4.07	1.59	ns
Care responsibility	18.37	6.40	18.52	6.58	ns
Influence in decision making	8.22	2.45	9.71	4.46	ns
Availability	7.14	1.86	7.72	1.79	ns
SES	11.44	2.48	8.64	2.25	-5.02***
Opportunities for Caregiving Role Development					
Outside support of paternal role	14.05	4.18	13.64	5.87	ns
Quality of received fathering	14.11	5.28	12.96	6.71	ns
Work-to-family conflict	13.87	8.99	15.40	10.07	ns
Family Relationships					
Father adjustment	6.22	1.61	7.20	1.91	2.55*
Marital satisfaction	16.28	4.51	15.58	4.96	ns
Marital status [b]	3.81	.56	3.72	.74	ns
Overt affection to the offspring	11.35	3.00	11.76	3.91	ns
Living with offspring? [c]	1.27	.44	1.28	.46	ns

Note. Greater scores indicate greater or increased level of each variable attribute. Exceptions noted.

[a] 1=Father, 2=Mother, 3=Other

[b] 1=Single, 2=Widowed, 3=Divorced, 4=Married

[c] 1=Yes, 2=No

*$p < .05$ ***$p < .001$.

Multivariate Analyses

Hierarchical multiple regression analysis was used to examine the effects of various individual-level factors and microstructoral factors on paternal involvement in caregiving. Results of the regression analysis is shown in Table 12 (p. 101). With all predictor variables in the equation, the model accounted for 59% (adjusted R^2 54%) of variances in paternal involvement in caregiving.

Research Question 1.

Effects of Individual-level Factors on Paternal Caregiving

To what extent is paternal caregiving influenced by individual-level factors (i.e., father background and gender-related factor)?

Father background factors

Fathers' age and employment status were control variables and they were entered first as a block. Older age of fathers and being employed were related to decreased level of paternal involvement in caregiving but they were not statistically significant.

Gender-related factor

Hypothesis 1. Sex-Role Orientation

Fathers will participate more in caregiving role when the father has a greater feminine sex-role orientation.

Table 12: Regressions: Predictors of Paternal Involvement in Caregiving

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Individual-level Factors						
Background Factors:						
Father's age	-.012	.007	-.081	-.077	-.051	.054
Father employed (ref. Unemployed)	-.072	-.123	-.309*	-.308*	-.300*	-.154
Gender-related Factor:						
Father's level of femininity		.559**	.672**	.685**	.713**	.550**
Microstructural Factors						
Position within Society:						
SES			.435**	.436**	.447**	.429**
Non-White (ref. White)			.088	.083	.078	-.033
Opportunities for Caregiving Role Development:						
Work-to-family conflict				.025	.040	.081
Quality of received fathering				-.037	-.006	.038
Outside support of paternal role				.030	.058	.011
Gender of offspring with mental illness:						
Female offspring (ref. Male)					-.243*	-.254**
Family Relationships:						
Paternal adjustment						.454**
Marital satisfaction						-.279**
F **Change**	.204	38.651**	9.295**	.075	8.459*	10.333**
R^2 **Change**	.005	.309	.124	.002	.054	.106
R^2	.005	.313	.438	.439	.493	.599
Adjusted R^2	-.018	.289	.404	.384	.436	.543

Note. Standardized beta coefficients are reported.
*$p < .01$ **$p < .001$.

The second model included fathers' level of femininity. Consistent with the hypothesis 1, fathers' greater degree of femininity was significantly associated with increased level of paternal involvement in caregiving, $b = .559, p < .001$. Fathers' level of femininity explained a significant proportion of variance in paternal involvement in caregiving. Controlling for fathers' age and employment status, fathers' femininity level explained an additional 31% of the variance in Model 2.

Research Question 2.

Effects of Microstructural Factors on Paternal Caregiving

To what extent is paternal caregiving influenced by microstructural factors (i.e., position within society, opportunities for caregiving role development, gender of offspring with mental illness, and family relationship)?

Position within society

Fathers' SES level and race/ethnicity were entered together as a block in Model 3.

Hypothesis 2. Socio-Economic Level

Fathers will participate more in caregiving role when the father has a higher SES level.

Consistent with the hypothesis 2, higher SES level of fathers had a sub-

stantial direct effect on fathers' level of caregiving involvement, $b = .435, p < .001$. Being a member of diverse cultures did not have a significant relationship with paternal involvement in caregiving.

In our regression model (Table 12, p. 101), fathers' race/ethnicity did not have a significant relationship with fathers' involvement in caregiving.

Model 3 accounted for 44% of variances in paternal caregiving, explaining additional 12% of variances than Model 2.

Opportunities for Caregiving Role Development

Model 4 included work-to-family conflict, quality of received fathering, and outside support of paternal role.

Hypothesis 3. Work-to-Family Conflict

Fathers will participate more in caregiving role when the father has a lower degree of work-to-family conflict.

Counter to the hypothesis, there was no relationship between work-to-family conflict and the level of paternal involvement in caregiving.

Hypothesis 4. Quality of Received Fathering

Fathers will participate more in caregiving role when the father has a greater degree of positive perception toward the quality of fathering (caregiving) he received from his own father.

Counter to prediction, quality of received fathering(caregiving) that study participants received from their fathers did not have a direct effect on paternal caregiving involvement.

Hypothesis 5. Outside Support

Fathers will participate more in caregiving role when the father is receiving stronger outside support for the paternal caregiving role.

Contrary to expectation, levels of outside support that fathers receive from outside sources was not significantly related to increased levels of paternal caregiving.

In Model 4, none of those factors related to opportunities for caregiving role development had significant direct relationship on the increased paternal involvement in caregiving. Model 4 only explained additional less than 1% of variances than Model 3.

Gender of Offspring with Mental Illness

Model 5 included the gender of offspring with mental illness.

Hypothesis 6. Gender of Offspring

Fathers will participate more in caregiving role when the offspring with mental illness is a son.

As predicted, offspring's male gender significantly contributed to in-

creasing the level of paternal involvement in caregiving. Fathers' level of involvement decreased with a female offspring, $b = -.243, p < .01$. Model 5 accounted for 49% of variances in paternal caregiving, explaining additional 5% of variances than Model 4.

Family Relationship

Model 6, our final model, included father adjustment and marital satisfaction and both factors were significantly related to paternal caregiving involvement.

Hypothesis 7. Father Adjustment

Fathers will participate more in caregiving role when the father is more adapted to the family member with mental illness.

Conforming to our hypothesis, fathers' level of adjustment had a direct effect on increased level of paternal involvement, $b = .454, p < .001$.

Hypothesis 8. Marital Satisfaction

Fathers will participate more in caregiving role when the father is more satisfied with his marriage.

As expected, marital satisfaction was significantly related to fathers' involvement in caregiving. However, counter to our prediction, marital satisfaction had an inverse relationship with the level of paternal involvement, $b = -.279, p < .001$. Our final model accounted for 59% of variances in pater-

nal caregiving, explaining additional 11% of variances.

To examine whether fathers' marital status (married vs. unmarried) changes the relationship between study variables and the levels of paternal caregiving involvement, *marital status* was entered in regression as a moderator variable. Significant interaction (moderation) effects of marital status were observed for following factors among married fathers: Married*Work-to-family conflict ($b = .609, p < .01$) and Married*Living with offspring ($b = -.518, p < .10$). The model accounted for 63% of variances in paternal involvement in caregiving. Unmarried fathers also had significant interaction effects: Unmarried*Level of femininity ($b = -1.249, p < .05$), Unmarried*Work-to-family conflict ($b = -1.849, p < .01$), Unmarried*outside support ($b = 1.147, p < .10$), and Unmarried*Living with offspring ($b = .547, p < .01$). The model accounted for 63% of variances in paternal caregiving.

Summary

In the final regression model (Table 12, Model 6, p. 101), factors that had a significant relationship with fathers' involvement in caregiving included fathers' level of femininity, SES, offspring's gender, paternal adjustment, and marital satisfaction. Among these factors, fathers' femininity level was the most important factor in the prediction of paternal involvement in caregiving, $b = .550, p < .001$. Paternal adjustment was the second important predictor, $b = .454, p < .001$, SES level was the third, $b = .429, p < .001$, marital satisfac-

tion was the fourth, $b = -.279, p < .001$, and gender of the offspring (female offspring) was the last, $b = -.254, p < .001$. Model 6 suggests that fathers from diverse cultures may have a decreased level of involvement compared to Anglo-American fathers, but the relationship was not statistically significant. Our final model accounted for 59% (Adjusted R^2 54%) of variances in paternal involvement in caregiving.

Consistent with our hypotheses, increased level of paternal involvement in caregiving was achieved first, when the father had a greater feminine sex-role orientation; second, when the father was more adapted to his offspring with mental illness; third, when the father had a higher SES level; fourth and finally, when the offspring with mental illness is a son. Marital satisfaction was another key factor to influence the level of paternal involvement, but counter to our prediction, it was inversely related to fathers' caregiving involvement. Unexpectedly, insignificant effect was observed in terms of outside support, quality of received fathering (caregiving) experience, and work-to-family conflict on fathers' involvement in caregiving.

CHAPTER 6 DISCUSSION

This study suggests that the *symbolic dedication of mothers* (Howard, 1998) to care for their family and offspring is equally reflected in paternal caregiving behaviors. Fathers in our study demonstrated high degree of affection and commitment toward their offspring with mental illness, and many of them were actively involved in providing care to their offspring. In addition, there were groups of fathers who may be limited in their financial ability, but are willing to get involved with their offspring by providing high level of emotional support. It is true that these fathers were special groups of fathers, and they should be distinguished from other groups of more detached and uninvolved fathers. But the reports of the fathers' in this study do reflect, to some degree, the difficulties that may be faced and experienced by all other groups of fathers of offspring with mental illness. The major struggle experienced by these fathers seemed to be related to the difficulty in diverging from the dominant gender role expectations to become a nurturant caregiver.

Research Question 1.

Effects of Individual Factors on Paternal Caregiving

To what extent is paternal caregiving influenced by individual-level factors (i.e., father background and gender-related factor)?

Father background factor

Fathers' age and employment status were controlled in this study. Although they were not significantly related to paternal caregiving in our regression model, they do have implications for the level of paternal caregiving. Age is clearly correlated with the health and energy level of fathers, and fathers' retirement may have a direct effect on increasing paternal involvement in caregiving. For example, one father reported that since his retirement, he was having greater opportunities to take care of his offspring. He stated that the father's role changes with age: young fathers focused more on a provider role for the family but older (retired) fathers could focus more on the caregiving role. Miller and Cafasso (1992) comments that retirement may heighten fathers' involvement in caregiving as an outlet for growing domestic interests. Researchers believed older (retired) men may have greater resilience and more gratification in family caregiving.

Gender-related factor

As expected, internalized sex-role orientation of fathers had a powerful effect on how they perform the caregiving role. In this study, fathers' level of femininity was the most important factor in explaining an increase in fathers' involvement in caregiving. Although father's level of involvement did not significantly differ based on four different types of sex-role orientation (i.e., masculine, feminine, androgyny, undifferentiated), fathers with more feminine sex-role orientation did have a heightened level of involvement in caregiving. This finding is consistent with previous research indicating that sex-role orientation acquired from early socialization is very powerful in shaping the nature and degree of caregiving involvement (Lorber, 2003; Chesler & Parry, 2001; Fuller-Jonap & Haley, 1995; Martin & Parker, 1995; Segal, 1990; Risman, 1987; Chodorow, 1978; Bem & Bem, 1976). However, it is yet unclear whether the feminine sex-role orientation precedes active paternal involvement. The opposite direction is also possible when fathers who participate in caregiving role develop their caregiving skills (e.g., being sensitive of others' needs, nurturing), and in turn, become more feminine oriented in their sex-role orientation.

Since fathers' sex-role orientation may be the key factor in influencing paternal caregiving behavior, fathers who score low in femininity may have neither the motivation nor the skills to provide primary care for their offspring. As a result of gender-appropriate role socialization, fathers may have developed a very stable gender trait that defines caregiving as "mothering," a traditional

female role. Pleck (1985) raised an interesting question related to this account:

> But in the minds of many, a deeper question remains: even if all the variance in men's family work time could be explained through a combination of these social factors, is not the real source of men's low participation (in caregiving) that men simply do not want to do it?.....Does this low participation occur because of factors which men are really not responsible for, or do men bear an ultimate responsibility for it? (p. 156)

Currently, it is unclear whether fathers need social, economic, and emotional resources to perform in the caregiving role (Mathew et al., 1990) but it is clear that to produce more nurturant fathers, they need to be socialized to "care." According to Chase-Lansdale and colleagues (1995), to become caring individuals, they need to acquire social skills, especially the ability to interpret and respond according to others' emotions and needs. Researchers emphasize the early developmental role of families for producing caring individuals.

It is important for fathers to actively reshape fatherhood roles for themselves, and bring about individual changes to become more nurturing. However, these fathers are not free from those socially enforced traditions, values, norms, and standards that prevent them from actively participating in caregiving. The production of nurturing fathers may be best achieved by social reorientation of traditional definitions about marriage, fatherhood (transcending biology), and male economic responsibility.

Research Question 2.

Effects of Microstructural Factors on Paternal Caregiving

To what extent is paternal caregiving influenced by microstructural factors (i.e., position within society, opportunities for caregiving role development, gender of offspring with mental illness, and family relationship)?

Position within society

Father's SES level had a more distinctive effect on paternal involvement than race/ethnic membership. The SES level of the fathers was the third important factor for predicting paternal involvement in this study. Fathers with high SES were involved more actively in caring and supporting their offspring with mental illness. The finding of the significant role of SES on paternal caregiving is consistent with previous literature (Dowd, 2000; Coley & Chase-Lansdale, 1999; Johnson, 1998b; Harris & Marmer, 1996).

Father's race/ethnic membership did not have a profound effect on paternal involvement. This study may have failed to explore what roles are played by ethnicity, race, and culture due to the small number of fathers from diverse cultures. Although this study attempted to include fathers from lower SES and fathers from diverse cultures, the majority of our sample consisted of Anglo-American fathers.

An individual's identity is developed from socially predefined statuses of gender, race, ethnicity, education, income, and social class. The socially

assigned statuses are powerful enough to limit or create opportunities for individual achievement and (caregiving) role development (Lorber, 2003). Markus and colleagues (2001) conducted in-depth interviews with 83 adults and found that people with higher level of education felt more empowered to effect change. For example, when asked about the way respondents deal with obstacles, high school educated respondents portrayed a sense of self as "embedded in," "adapting to," "constrained by external situations," "surviving obstacles," and "hanging tough." However, college educated respondents believed they were able to make changes in obstacles, and placed a great emphasis on "taking initiatives." The level of SES has an important influence for family caregiving. Johnson (1998b) observed 180 adults with mental illness and their families, and found that declining level of the SES not only decreased the level of family functioning (i.e., adaptation, competence) but also had an adverse effect on the functioning of the member with mental illness.

Opportunities for Caregiving Role Development

Counter to prediction, there was no significant relationship between levels of paternal involvement and the opportunities for caregiving role development. This should not be interpreted that outside support, received fathering, and work-to-family conflict are unimportant for paternal involvement in caregiving. Significant zero-order correlation was observed between each single variable and paternal involvement in caregiving. However, when

these variables were entered together as a block in the regression model, none of them appeared statistically significant. There is a possibility for moderator or interaction effect, which occurs when an independent-dependent variable relationship is affected and changed by another independent variable (Hair et al., 1998). Examination of moderator effects are beyond the scope of this study. Future study is needed to determine whether the moderator effect is present.

Outside Support for Paternal Role

There was no evidence of direct effect of outside support, on the level of paternal caregiving. The sample in this study included a large proportion of Anglo-American fathers from middle to upper social class. For these relatively affluent families, outside support from extended families, extra-familial members (e.g., friends, neighbors, church members, colleagues at work), and support from mental health institutions may not have great importance as it might be to lower SES families or families of diverse cultures (Lefley, 1997). If our sample included a relatively large portion of African-American, Mexican-American, Asian American, and Native-American fathers, we may have been able to identify the important role of outside support on paternal involvement since they share similar cultural values that emphasize family and community support (McCallion et al., 1997).

Outside support for fathers may not have appeared significant in this

study because it is not an accurate source of support for fathers. Wintersteen and Rasmussen (1997) interviewed 25 pairs of husbands and wives separately, and found interesting differences between them. To cope with offspring's mental illness, fathers' typically relied on their work or hobbies, whereas mothers' sources of support came from their friends, other family members, and support groups. Einam and Cuskelly (2002) also suggest that paid jobs outside the home can act as a protective mechanism for fathers who are caring for offspring with mental illness. They often have a negative self-evaluation as a parent because their offspring developed mental illness. Job involvement can reduce this negative self-image because it provides a chance to demonstrate one's competency.

In Wintersteen and Rasmussen's study (1997), fathers rarely talked to friends or family relatives about their offspring (with mental illness) for support, and did not perceive support groups or organizational services as helpful. In Greenberg's study (2002) fathers tended to socially interact with other persons who are primarily in relationships with their spouse. Most of the time, fathers cited their spouse as the primary source of their support, and given this support, others' support had little effect on reducing their emotional distress.

Fathers may not rely on others for support because the support they receive from them is often insufficient or inadequate. In Chesler and Parry's study (2001) with 167 fathers of children with cancer, many fathers stated how their male friends were unprepared to comfort them. One father shared

his experience of talking to his male friend about his child's cancer:

> My best buddy said, "Goodbye." Then he went away and cried because he couldn't handle it. There seemed to be little concern for the father at times. People would constantly ask me how my son was doing, which was understandable, but then shift to "How's your wife taking all this?" I don't ever recall anyone ever asking me, "How are you taking this?" I guess they just assumed I would be okay. I felt very alone (p. 373).

Wintersteen and Rasmussen (1997) caution that fathers' heavy reliance on their spouses for emotional support may doubly burden mothers since they are providing care to their husbands as well as their offspring with mental illness.

Quality of Received Fathering

One other unexpected finding in this study was the insignificant link between fathers' level of caregiving involvement and the quality of fathering (caregiving) they received from their own fathers when growing up. Previous research suggests a link between "being fathered" and "being a father" (White, 1994), stating that the fathering men received (from their own fathers when growing up) may work as a reference point for them to construct their own understandings and practices of fatherhood (Lorber, 2003; Chesler & Parry, 2001; Zoja, 2001; Coley & Chase-Lansdale, 1999; Daly, 1995; White, 1994; Segal, 1990; Barnett & Baruch, 1987). Possibly, this reference point itself may be unclear or inconsistent. There is no consistent social agreement on what the role of "good" or "current appropriate" fathers is, and limited guidance

is available from research to assist in the construction of a *new* nurturing fatherhood (Coley & Chase-Lansdale, 1999). Emotional absence and physical unavailability (due to being an economic provider) are all socially accepted dimensions of fatherhood. These dimensions that men look up to as a reference for "being a father" are so broad in its parameters. It may bring confusion to men (White, 1994). Individual fathers may develop a very different definition of what good fathering is. Some fathers may perceive their quality of received fathering as very positive, although their fathers were mostly unavailable in their lives.

Work-to-Family Conflict

Another unexpected finding of this study was the low level of work-to-family conflict, reported by fathers. It was assumed that underlying gendered assumptions and norms at work will afford fathers with less flexibility and fewer accommodations which will in turn, limit their ability to cope and support their family members, and prevent them from devoting their energy to provide care to their offspring with mental illness. There may be reporting biases due to the tendency for men to underreport their distress (Lutzky & Knight, 1994; Horowitz, 1992) and this needs further exploration. But it is still surprising that only few fathers agreed that their job posed barriers to their involvement with their offspring. This connects with our previous discussion that fathers may have limited motivation to participate in caregiving due to internalized

gender role expectations.

Gender of Offspring with Mental Illness

Fathers showed higher involvement in caregiving with sons than with daughters, which is consistent with previous research findings (Williams & Radin, 1999; Harris et al., 1998; Rodrigue et al., 1992). In a 20-year follow-up study with 59 fathers by Williams and Radin (1999), as children grow up, fathers' high involvement was more likely to be kept up with sons than with daughters.

Fathers' level of participation seems to be a result of their level of affection toward the offspring. In fact, fathers' preference for their offspring was closely related to the level of father participation in caregiving (Markowitz, 1984). Fathers may feel closer to or more comfortable with sons because of same-sex. Fathers may feel like they could better understand and assist sons than daughters because they know what it was like to grow up as a man. This closeness or comfortable feelings toward sons may appear as more affectionate caregiving behaviors. According to Essex (2002), intimate feelings toward their offspring with mental illness can be a rewarding aspect of caregivng for fathers. Affection for the offspring with mental illness may facilitate parental adaptation, reduce stress in performing caregiving task, and provide rewards of caregiving. In other words, intimacy with the offspring is highly correlated with emotional reward while the lack of intimacy is associated with caregiver

burden and stress (Heru, 2000). Therefore, fathers with more affectionate feelings toward their offspring with mental illness are expected to participate more in the caregiving role. However, among the key factors related to increased level of paternal involvement, gender of offspring was the least important factor.

Family Relationship

Father Adjustment

The second important predictor for paternal involvement in caregiving was fathers' level of adjustment to their offspring with mental illness. Fathers with high level of adjustment "loved" or "enjoyed" being around their offspring and had little or no difficulty in meeting the needs of their offspring. The importance of individual adjustment is well discussed in the study of Markus and colleagues (2001). The study emphasizes the importance of taking care of one's self in order to care for others. Markus and other researchers argue that being attentive to one's self should not be considered as in opposition to caring for others but as a key component that enables individuals to provide care for others.

In this study, we compared married and unmarried fathers in terms of their level of involvement in caregiving of their offspring with mental illness. Sagi & Sharon (1984) suggests that in two-parent families, the mother traditionally assumes primary responsibility for the child with mental illness but

in families where the mother is no longer available to care, the single father manifests his full ability to adapt to the situation and function more than adequately. Unmarried fathers who are living with their offpspring may assume greater responsibility in caregiving for their offspring than married fathers since unmarried fathers are likely to be primary caregivers. However, in this study, there was no evidence that unmarried fathers have better adjustment level than married fathers. This research finding is yet tentative and further investigations on both of two-parent and one-parent families are needed on the level of their adaptation, functioning, and service needs. In addition, father adjustment may be closely related to the severity of offspring's mental illness. Fathers of offspring with severe mental illness would find it more difficult to make adjustments than fathers of offspring with mild mental health problems. Future work is needed to examine the impact of offspring's condition on fathers' adjustment.

Marital Satisfaction

Finding that marital satisfaction was inversely related to paternal involvement in caregiving was surprising in light of previous research. Studies on marriage and family generally suggest fathers increase their level of involvement with their offspring when they are more satisfied with their marriage. In our study, fathers seemed to be more satisfied with their marriage when they were less involved with the caregiving role.

We interpret this finding in terms of mothers' expectations for their spouses' involvement. In a happy marriage, mothers can play a significant role in influencing fathers to assume an active paternal role. If mothers have high expectations for their spouses' involvement, she will encourage the father to actively participate in caregiving (Mcbride & Darragh, 1995). On the contrary, mothers can restrain fathers from getting involved as well. A large proportion of fathers in our sample were over 50 years of age, and it is likely that their spouses belong to the similar age group. These mothers may value established gender role division and resist men's changes, and for them, fathers' participation in caregiving role can be seen as an intrusion into their own *female turf* (Chesler & Parry, 2001). Assuming total responsibility in caregiving may be thought of as a form of power, and some mothers may perceive they were loosing the power by sharing the caregiving role with their spouses. Or, they may believe that caregiving tasks should be completed their own way and are unwilling to let fathers get involved. However, research on maternal caregivers generally suggest that mothers are exhausted and feeling depressed with shouldering the burden of caregiving responsibility, and want more active involvement of their spouses.

The other, and maybe more plausible explanation for the inverse relationship between marital satisfaction and paternal involvement centers around fathers' attitude toward the caregiving role. As discussed previously, the most important factor for increasing fathers' involvement was fathers' feminine oriented sex-role orientation. Fathers' with more feminine personality traits

showed heightened level of involvement. From gender-appropriate role socialization, fathers may have developed a definition of caregiving as a women's role. As a consequence, fathers may not have the motivation to care, although they are capable of caring. Fully 79.8% of our sample consists of fathers over 50 years of age. Older generations are more likely to have a more rigid gender role definition than younger generations. These fathers may hold an attitude that caregiving is women's work that they, the women, should take care of. Fathers in our sample seemed to feel more satisfied with their wives and their marriage when their wives were taking care of their offspring very well (without fathers' help). Similarly, in Howard's (1998) qualitative study with 12 fathers of offspring with schizophrenia, one father commented: "This has been a positive experience for me. My wife's devotedness has increased my love for her. I am more concerned for my other children (without schizophrenia)" (p. 409).

There is a belief that men will participate in caregiving only when they do not have wives to do it for them. After reviewing recent literature regarding fatherhood and family, Dowd (2000) suggested that fathers could nurture children just as well as mothers, and their parenting would be very similar to mothering. Examination of the interaction or moderation effects related to fathers' marital status provided interesting findings. For married fathers, work-to-family conflict was positively related to the paternal involvement in caregiving. Married fathers may maintain their level of involvement at high level (regardless of the heightened work-to-family conflict) to conform with

their spouse's expectation. On the contrary, for unmarried fathers, increased work-to-family conflict resulted in the decreased level of paternal involvement.

In this study, married fathers were more likely to be living with their offspring. For unmarried fathers, not living with their offspring may not mean less commitment to caring but imply no other option available (Seltzer et al., 1997a). These unmarried fathers may lack skills to provide care to their offspring with mental illness. Another interesting finding was that unmarried fathers with greater degree of feminine oriented sex-role orientation decreased their caregiving behaviors. Unmarried fathers with greater level of femininity may be more vulnerable to severe depression and stress. Outside support seemed to play an important role for these unmarried fathers to make adjustments and increase their level of participation in caregiving.

Summary

In this study, feminine-oriented sex-role orientation of fathers was the most important factor to increase fathers' involvement in caregiving. High level of paternal adjustment (to the offspring with mental illness) was the second important factor that brings heightened level of paternal involvement. Fathers' participation increased along with the level of their socio-economic status while their race/ethnicity membership had a negligible effect. The next important factor in increasing fathers' involvement was their level of marital satisfaction. Counter to our expectation, marital satisfaction was inversely re-

lated with the degree of fathers' caregiving behaviors. Fathers reported greater marital satisfaction when they were less participating in caregiving. Gender of the offspring with mental illness also had a significant influence on increasing fathers' involvement, but it was the least important predictor. Fathers were more involved with sons than daughters. Unexpectedly, fathers' involvement level did not change based on the differentiated levels of outside support, quality of received fathering (caregiving), and work-to-family conflict.

CHAPTER 7 IMPLICATIONS AND CONCLUSIONS

Social Work Practice

An increasing number of fathers are committed to get involved with their children, but structural as well as individual barriers often limit the range of activities and discourage their involvement. The findings of this study that father's sex-role orientation may be the most important key factor in terms of increasing paternal involvement gives important implications for providing services to families caring for offspring with mental illness. Socially enforced gender role expectations around masculinity may inhibit fathers from assuming a primary caregiver role. Unlike mothers, fathers have not been socialized to become nurturing caretakers while they were growing up. As a result, many fathers may not understand the functions and demands that are related to being an actively involved father. Social work interventions can help fathers with the socialization process to become a nurturing father through support and education programs (Mcbride & Darragh, 1995).

Community-based services for persons with mental illness, however, have been less well developed than such services for persons with other types of disability (e.g., mental retardation), which places a greater burden on the family with an offspring with mental illness. Due to socially embedded stigma, families of offspring with mental illness are receiving less social support than families with a member with other types of disabilities (Seltzer et al., 1997b). On top of this, only a small number of social work treatment programs, including parent groups, parent meetings, and parent conferences, have targeted fathers. The lack of paternal involvement was identified as a major factor in generating fathers' dissatisfaction with professional services (DeChillo et al., 1994). The importance of collaboration between professionals and families is strongly emphasized for bringing successful outcomes in fragile families that are caring for a member with mental illness (Curtis & Singh, 1996; Mcbride & Darragh, 1995; DeChillo et al., 1994). However, little empirical work has been done to evaluate the impact of parent-education and support programs for fathers, and it calls for more research to better understand how social work interventions can empower fathers and encourage them to get actively involved in caregiving role. Partnership between the father and the service systems is critical, given the mutual relationship between father involvement and empowerment.

Social work intervention efforts should first concentrate on father-child relationships to increase fathers' motivation and initiative for increased paternal involvement. This study emphasized the importance of paternal ad-

justment to their offspring with mental illness. Fathers will increase their involvement with their offspring only when they feel comfortable around their offspring and feel confident in meeting the needs of their offspring. Building a stronger father-child bond can promote higher levels of paternal adjustment, and potentially motivate and sustain them to stay involved with their offspring and families (Pleck, 1985). Disadvantaged fathers often need more assistance in building positive relationships with their children. Many of these disadvantaged fathers may have had limited involvement with there own fathers, due to deleterious individual and situational circumstances (Johnson, 1998b).

There is a growing need for more father-centered interventions that aim at improving and strengthening the father's capacity to rebuild relationships in the family. In this study, marital satisfaction was closely related to the level of paternal involvement but in a inverse way. Fathers were more satisfied with their marriage when they were less participating in caregiving. But if we have asked the same question to these fathers' spouse, we may have gotten a different answer. Previous research consistently identifies the heightened levels of maternal depression and burden when a mother is caring for a member with mental illness with limited support from their spouse. We should more clearly attend to both individual fathers' and mothers' needs, their situational circumstances, and their life stages to provide more individually focused treatment and programs.

For fathers of offspring with mental illness, there is a need for social work interventions that provide emotional support by attending and responding to

their high levels of interpersonal distress. Another important intervention is providing psycho-educational programs for families that care for persons with mental illness. Maintaining control over a psychiatric crisis situation is one of the important concerns that families have when caring for a family member with mental illness. For example, one father of offspring with mental illness reported how difficult it was to deal with his loved one when he (person with mental illness) was having an active psychosis: "My wife tends to try aid and comfort, believe it or not, it bothers him to no end." In a study by Mays and Lund (1999), one male caregiver stated, "There's always that possibility... a tendency for it to get out of control"(p. 26). Another father explained, "I had to lock my doors at night, for fear that he [the son] might hurt me. He was doing everything to fight it... but I had to stick with him. I could not give up" (p. 26). Due to the cyclical nature of mental illness, parents may not know how their offspring will react in everyday interactions. For these families, a psychiatric crisis is an important factor that can end the period to live with their offspring (Seltzer et al., 1997b). Social interventions can provide information on how these families can effectively manage and respond to psychiatric crisis of their offspring.

Finding of this study identified the level of paternal involvement declined along with the declining level of SES. This class-stratified level of caregiving may threaten healthy mental health outcomes and overall well-being of the person with mental illness in lower SES families. We should not define fatherhood in a way that reinforces this class-differentiated quality of care for

persons with mental illness. The narrow conceptualization of fatherhood that centers around economic provider role is reflected in clinical settings should be modified in order to improve disadvantaged fathers' status and their functioning as fathers (Johnson, 1998b). Social work interventions should develop better strategies to increase paternal involvement, especially with disadvantaged families, and to facilitate paternal role functioning, improve family relationships, and as a consequence, promote well-being of the offspring with mental illness.

Another important component of social work intervention will be to provide job counseling, job training and other employment support for disadvantaged fathers. Such intervention will include providing employment support including: work readiness skills, job seeking and retention skills, and introducing educational opportunities that are available through high school, GED, vocational, technical, college, and military service. Involvement in work offers an opportunity for increased social networks, a source of support, and also provides a chance to demonstrate (to oneself and others) that one is competent. Positive information about self and employment is very important in reducing negative self image, which is often present with disadvantaged fathers.

Public Policy

Many fathers have begun, individually and in groups, to question externally enforced notions of masculinity and then work on these issues (Hussey, 2003). Men started to discuss and reflect on their painful experience of yearning for their fathers while they were growing up (Phares, 1996). Publications, such as, *Iron John: A Book about Men* (1990) by Robert Bly and *Fire in the Belly: On Being a Man* (1991) by Sam Keen contributed to brought issues of fathers and masculinity to public attention.

More and more, differences between paternal role and maternal role are diminishing (Kraemer, 1999) and there is a need for a more broad definition of paternal involvement that includes not only financial support but also emotional contributions. Current narrow definitions of paternal involvement which mainly focuses on the economic contribution has the potential of estranging fathers from the family. The disappearance of the father is not only a source of great pain for fathers, but also a source that discourages family formation, paternity establishment, and father involvement in general. Zoja (2001) raises concern that the absence of father is pervading the present-day world, and requests us to continue to search for him:

> Taken as a whole, the advance of the absent father pursues this route: from America, to Europe, to the third world; from the major to the smaller cities, and then to rural communities; and, finally, from the upper to the lower reaches of the social scale. For the family, the father didn't die in the war, but at the moment of returning home (p. 234).

Public policies are in part, responsible for making fathers disappear in

the family. Welfare policies are greatly reinforcing the "good provider role," and are implying that paternal involvement is limited to providing economic support. Excluding fatherhood from the family context and only regarding it as legal duties imply that the financial provision is the only component of responsible fatherhood (Roy, 1999, as cited in Roy 2000). In *The hearts of men*, Ehrenreich (1983) discusses the demise of breadwinner ethic that has made men "unquestioning" and "obedient" to the prescribed role that men should provide for the family. This breadwinner ethic can further push disadvantaged fathers to separate themselves from their families out of shame and guilt (Furstenberg, 1988). In fact, fathers are more likely to move out of marriage when they cannot provide for their children, and mothers are often less likely to want them remain. Fathers' overall involvement in their families can be marginalized, if they have failed to provide, and in turn, they can lose all opportunities to get involved with their children.

The men's movement is emerging, on the other hand, as a way to empower fathers and bring fathers to get involved in their children's lives. Pressure groups are organized and are making vigorous action in the legal system to strengthen paternal rights over children following separation or divorce (Segal, 1990). The Fatherhood Responsibility movements described "fatherlessness" as "one of the greatest social evils of our generation" and "an engine driving our worst social problems" (Gavanas, 2002, p. 215). Starting from the early 1990s, there have been presidential and vice-presidential federal initiatives to strengthen father's role in the family. Organizations like the National Father-

hood Initiative and the National Practitioners Network have also worked to strengthen fatherhood responsibility. In *The Father Factor* (1994), Biller and Trotter suggest that the "immediate goal of the men's movement" is "to heal the wounds inflicted by the missing father" but the "ultimate goal" must be to "ensure that the sins of the father are not visited on the next generation" (p. 8).

There are important social work interventions that can potentially influence macro-level structures to permit greater paternal nurturing. Institutional and structural barriers to paternal involvement should be addressed by social work intervention and efforts should be made to minimize such barriers. Initiating and supporting father networks or father movements for the fragile families (with low income) may be a way to start.

It will be important to advocate for public or mental health policies that encourage stronger father-child relationship. These policies should not marginalize low SES group fathers due to their limited economic contribution in the family. Increasingly, fathers are realizing the benefits of becoming a "new father" who is more emotionally involved with his children and has gratification and satisfaction in those close relationships (Dowd, 2000; Furstenberg, 1988). Increased father involvement will eventually improve family relationship, functioning, and child well-being outcomes. Toward this end, increasing father involvement should be a high priority of welfare policies aimed at restoring and strengthening poor families. Improving family relationships will provide a positive context in which fathers can assume active paternal roles.

Public policies can be formulated to encourage more father involvement with a consideration on the potential contributions of fathers in the family.

In addition, social work interventions should intervene with mental health policies which are creating barriers for family caregiving. For example, services for mental health are carved out from the managed care arrangements and are being separately costed. The linkage between mental and physical health is necessary for more integrated services, and the better mental health outcome of the member with mental illness. Although "the mental health is a key to the physical health" (K. Davis, presentation at 2004 NAMI Washington convention), current mental health policy is creating barriers for the families with a member with mental illness. These families are left with limited access to quality services. Social work interventions should advocate, particularly for low SES families, to ensure these families have opportunities to receive more advanced and effective treatments (which may be expensive and will be less available to disadvantaged families).

Future Research

This study explored the paternal caregiving experience based on a homogeneous group of fathers which included a large number of middle to upper class Anglo-American fathers. Further studies that involve fathers across diverse cultures and social classes are necessary to better understand how

culture, ethnicity, and socio-economic factors influence fathers' perception of fatherhood, and their actual caregiving behavior. Culture-specific information about fatherhood and father roles across various groups of fathers may be important for guiding social work intervention but the information should not be used to marginalize certain types of fathers from receiving service.

The potential role of siblings is increasingly gaining attention in caregiving and mental health research. Family caregiving for a member with mental illness is mostly provided by parents but this parental care will ultimately end when the parents die or they are no longer able to provide care. Siblings may be an important source to take on the family caregiving responsibilities. However, recent research study reports that the siblings of adults with mental illness perceive their interpersonal experiences as mostly negative. Siblings of adults with mental illness may fear that they too will get mental illness or, experience envy and resentment because of the extra attention that their parents have been devoting to the member with mental illness (Lynch et al., 1987). If future studies replicate this finding, social work services should be directed to recover those sibling relationships in families with a member with mental illness. More research is needed on the sibling relationships that include a member with mental illness. The level of intimacy, connectedness, and assistance exchanged between these siblings should be explored over time to see how these relationships change with different caregiving situations. The role of siblings may be critical for the future care of a member with mental illness. Potential role of siblings need future exploration as they may be the

next generation caregivers.

The issue of family resiliency and healthy adjustment of the caregiver is another important area that deserves further research. According to Gallagher, Cross & Scharfman (1981) and Belcher (1988), it would be incorrect to automatically assume that every family is having trouble with the offspring with disability. For example, in this study, one father in his 50s had 8 children, and 4 of them were diagnosed as having emotional disturbances. "They are gifts from God," he said, explaining that he and his wife had been unable to have babies for 8 full years without any reason. He believed that all of his 8 children were "blessing from God" and "precious gifts" that He allowed to his family. Certain families with strong personal resources are able to transform the experience of having offspring with disability into a positive opportunity for personal growth (Bicknell, 1988). Research on family resiliency and key factors that are related to promoting such resilience may generate new information for social work intervention to help empower families of a member with mental illness.

Limitations

The sample of this study was mainly drawn from Austin and San Antonio, TX, using a nonprobability sampling method. The groups of fathers who showed interest and agreed to participated in this study were self-selected

groups, and not representative of all fathers of offspring with severe mental illness. Participating fathers were more likely to be fathers who are already involved in the caregiving role. The results of this study may not be generalizable to other groups of fathers who are very uninvolved with their offspring. In addition, the sample of this study was quite homogeneous, with the majority being middle to upper class Anglo-American fathers. We were unable to do between-group comparisons across various cultures and social lines. Further research should continue to investigate the unique experiences of the male caregiver, using a larger, probability-based sample with diverse groups of fathers.

Second, due to the small sample size ($n = 104$) employed in this study, increased statistical error may become an issue. As a result, the margin of error is expected to be relatively large, which will, in turn, decrease the precision of prediction. However, statistical power, or the probability of detecting a significant relationship if it actually exists, is not problematic in this study. With the sample of 104 participants and 11 independent variables, R^2 values of approximately 15% and above is detected statistically significant at .05 significance level (α) with a power of .80 (Hair et al., 1998).

Third, this study is only able to examine the separate impact of each individual-level or microstructural factors on the level of paternal involvement in caregiving. Therefore, the interaction dynamics as well as the directionality among the set of variables could not be identified. Findings of this study cannot give information on causal inferences between variables.

Fourth, this study employs a one-time survey method which may only describe a particular point in fathers' life cycle, and therefore, it is unable to depict how paternal caregiving changes over time as the offspring's condition changes. More research with longitudinal perspective is needed to examine how fathers manage transitions in the caregiving experience and access the direct and indirect effects of paternal caregiving on long-term offspring (with mental illness) and family outcomes.

Finally, this study has focused primarily on fathers' caregiving experiences. For a more comprehensive understanding of family caregiving, further research should attend to both fathers' and mothers' experiences dealing with the challenges of caring and supporting their offspring with mental illness. The nature and degree of paternal involvement in caregiving may be susceptible to the changes in family dynamics. For example, employment of spouse may play a significant role in increasing the level of paternal involvement. Future research on the role of family dynamics may deepen our understanding on parental caregiving, including its incentives and barriers.

Conclusions

> "Mommy, if the doctor brings the baby in his bag, and if Santa Claus brings us toys; if God will punish me when I am bad, and if money grows on trees, why do we need daddy? (Dee Applezweig, 1971, as cited in Goldberg, 1977)"

This study has benefits of identifying key factors that have an influence

on increasing the level of paternal involvement in caregiving. Findings of this study will be an initial step toward increasing our understanding of fathers of offspring with mental illness. The results of this study provide preliminary research evidence that may be helpful to future studies involving more sophisticated methodology as well as a larger multi-ethnic sample. Potential benefit of this study is in creating new knowledge that can be applied towards increasing the involvement of fathers of offspring with severe mental illness in both affective and instrumental caregivng roles. As this study finding suggests that fathers' sex-role orientation may be the most dominant factor in determining father's caregiving behavior, it suggests that high degree of masculine identity may prevent fathers from participating in the caregiving role. Due to this internalized sex-role orientation, fathers may neither have motivation nor skills to become caregivers because they were deprived of the necessary opportunities to develop their nurturing aspects. Microstructural factors (i.e., fathers' SES level, paternal adjustment, marital satisfaction, gender of offspring) also play an important role in increasing fathers' involvement. But fathers' deeply rooted self-definition (i.e., sex-role orientation) seemed to have greater influence than situational context. To produce more caring fathers, father education programs and support groups are recommended to encourage individual changes.

Individuals may vary on the components of gender-based orientation on their individual characteristics, but they must fit into the prescribed gender image and status their society recognizes (Lorber, 2003). The image of "the

father" has been a mighty one, historically: "The father as God, God the father, may be one of our most powerful mythologies" (Segal, 1990, p. 28). In *The hazards of being male*, Goldberg (1977) argues that this "external social conditioning" of "predefined *masculine* roles" has been so powerful that it has "all but destroyed individual's ability to be self-aware" (p. 183). Goldberg predicts that men will ultimately reject "externally imposed" *masculine* roles and liberate themselves from them, not for ideological reasons but simply because they are "painful" and "self-destructive" (p. 183):

> "The free male will reclaim his total self, coming increasingly in contact with his own unique and individual rhythm.... The free male will constantly reaffirm his right and need to develop and grow. He will celebrate all of the many dimensions of himself, his strengths and his weakness, his achievements and his failures, his sensuality, his affectionate and loyal response to women and men (p. 184)."

Although Goldberg's glossy argument is tempting, it seems almost impossible that a man can have the power to "free" himself from the historically enforced "rigid" (gender) roles, rejecting the "repetitive" and "stereotyped" role behaviors. Without social acceptance and support, and without cultural coordination and guidance toward new fatherhood, men may not become caring fathers.

As a step to "redefine fatherhood" (Dowd, 2000), and to make the transition from traditional fatherhood to a more nurturant and caring fatherhood, the society and workplace need to be reoriented toward its definition of fatherhood. The component of economic support has been critical in defining

fatherhood, traditionally. The nurturant, loving, caring aspects of the fatherhood were often neglected. Social reinforcement on the economic ability of fathers mainly resulted in limiting the opportunity for fathers to participate in caregiving. However, taking care of the economic issue is necessary for insuring the well-being of dependent offspring with mental illness. According to Dowd (2002), any redefinition of fatherhood will be meaningless without an economic support of the caregiving work. Parents of offspring with mental illness have been providing decades of unpaid labor as caregivers, but their contributions are not getting any reimbursements from the mental health service provision (Seltzer et al., 1997b). If these families do not have the economic support for caregiving, fathers may not increase their involvement to care, due to economic demands of their families caring a member with mental illness. And even though the workplace provided more flexible work hour options and allowed fathers to take times off from work, only affluent middle to upper class fathers may be able to take the advantage and participate more in caregiving.

In the individualistic American cultural that places great importance on one's own needs and rights, attending and responding to the needs and demands of others has been typically a secondary concern. Americans, especially men, are more accustomed to enumerate the rights they already have and to claim new rights, but are less used to having responsibility for others. Taking care of others' needs may sometimes cast one self to compromise one's own needs, and it may be seen as an intrusion to one's own right. On that account, for some fathers, becoming a caring father may be perceived as a

threat to their individualistic, *masculine* identity, in some fashion. On the contrary, mothers have always been bearing burden to attend to their child's needs and be responsible for the "whole well-being" of their child. Janna Smith, a psychotherapist, argues in her book, *A Potent Spell* (2003) that it is every mother's "passionate concern"to keep her beloved children safe and healthy. This potent spell of "mother love and the power of fear (of child loss)" has been making mothers vulnerable in many ways: It has been keeping mothers hovering around her child every day and night (metaphorically and often literally); mothers has been forced (through the influence of the potent spell) to bear more than her share of responsibility, if her child develops a mental illness. This maternal anxiety will never go away and will always be with mothers, but for that very reason, mothers should not be abused and exploited the way it has been (Smith, 2003).

Fathers can play an extremely important role in reducing burden, stress, and depression of the caregiving mothers, and reinforce family cohesiveness and stability. More balanced caregiving role allocation between fathers and mothers is very important for recovering and maintaining family's functioning to care for a member with mental illness.

Recent research on caregiving and mental health suggest the connection between caregiving for others and the well-being of the caring individuals (Markus et al., 2001). Clearly in the research findings, caregiving for others had psychological benefits for the caring individual. Active paternal nurture may not only contribute to better mental health outcomes of the offspring

with mental illness but also promote individual happiness of the father and the whole family.

APPENDIX A. SCALES AND PERSONAL BACKGROUND QUESTIONS

Scales

1. A Paternal Involvement in Caregiving Scale

2. The Kansas Marital Satisfaction (KMS)
   (Schumm, Paff-Bergen, Hatch, Obiorah, Copeland, Meens, & Bugaighis, 1986)

3. Quality of Received Fathering

4. Father Adjustment: Modified items from Single Parent Adjustment Scale (SPAS) (Singh & McBroom, 1992)

5. Outside Support of Paternal Role

6. The Work-Family (WF) scale
   from the Work-Family and Family-Work Conflict Scales (WF/FWCS)
   (Netemeyer, Boles, & McMurrian, 1996)

7. The Bem Sex-Role Inventory (BSRI) Short Form
   (Bem, 1974)

A Paternal Involvement in Caregiving Scale

The following questions will ask you about your involvement in caregiving.

I. Statement of Involvement

1. Who is the primary caregiver of your offspring?
   (Primary caregiver means the person who most often attends to your offspring's needs.)

   a. You

   b. Your spouse / long-term partner

   c. Other (please specify): _____

2. How involved are you in providing care for your offspring? Please check one.

Very Uninvolved	Uninvolved	Neutral	Involved	Very Involved
1	2	3	4	5

3. How involved are you in providing financial support for your offspring? (e.g., living expenses, medical insurance, etc.)

Very Uninvolved	Uninvolved	Neutral	Involved	Very Involved
1	2	3	4	5

4. How involved are you in providing emotional support to your offspring?

Very Uninvolved	Uninvolved	Neutral	Involved	Very Involved
1	2	3	4	5

II. Care Responsibility

Who in your family generally takes care of the following tasks? Please check one.

Tasks	Father always	Father more than mother	Father & Mother equally	Mother more than father	Mother always
5. Direct monitoring of your offspring	1	2	3	4	5
6. Helping your offspring with activities of daily living (e.g., shopping, personal grooming, etc.)	1	2	3	4	5
7. Setting limits for your offspring's behavior	1	2	3	4	5
8. Having sole responsibility for your offspring	1	2	3	4	5
9. Helping your offspring with personal problems	1	2	3	4	5
10. Helping your offspring to learn	1	2	3	4	5
11. Taking your offspring to doctor's or hospital appointments	1	2	3	4	5

III. Influence in Decision Making

Who in your family generally makes decision about the following? Please check one.

Decisions	Father always	Father more than mother	Father & Mother equally	Mother more than father	Mother always
12. When making decisions about education or work of your offspring	1	2	3	4	5
13. When making decisions about future living arrangements of your offspring	1	2	3	4	5
14. When making decisions about medical treatment and care of your offspring	1	2	3	4	5

IV. Availability

How available are you to your offspring? Please check one.

Items	Infrequently	Sometimes	Frequently
15. How often do you spend time with your offspring?	1	2	3
16. How often do you have meals with your offspring?	1	2	3
17. How often do you talk to your offspring?	1	2	3

The Kansas Marital Satisfaction (KMS)[a]

1. How satisfied are you with your marriage?

Extremely Dissatisfied 1	Very Dissatisfied 2	Somewhat Dissatisfied 3	Mixed 4	Somewhat Satisfied 5	Very Satisfied 6	Extremely Satisfied 7	Currently, Not Married 8

2. How satisfied are you with your wife as a spouse?

Extremely Dissatisfied 1	Very Dissatisfied 2	Somewhat Dissatisfied 3	Mixed 4	Somewhat Satisfied 5	Very Satisfied 6	Extremely Satisfied 7	Currently, Not Married 8

3. How satisfied are you with your relationship with your wife?

Extremely Dissatisfied 1	Very Dissatisfied 2	Somewhat Dissatisfied 3	Mixed 4	Somewhat Satisfied 5	Very Satisfied 6	Extremely Satisfied 7	Currently, Not Married 8

[a] Schumm, Paff-Bergen, Hatch, Obiorah, Copeland, Meens, & Bugaighis, 1986.

Quality of Received Fathering

1. How would you rate the quality of fathering (caregiving) experience that you received from your father while you were growing up?

Very Negative			Neutral			Very Positive
1	2	3	4	5	6	7

2. How positive a role did your father play in your life?

Very Negative			Neutral			Very Positive
1	2	3	4	5	6	7

3. How available was your father for you?

Very Negative			Neutral			Very Positive
1	2	3	4	5	6	7

Father Adjustment[a]

1. How well do you think you are able to meet needs of your offspring?

Fail to meet needs	Inadequately, with no problems	Adequately, with difficulty	Adequately, with no problems
1	2	3	4

2. How do you presently feel about being around your offspring?

Feel miserable	Feel stressed	It is tolerable	Enjoy it quite a bit	Love it
1	2	3	4	5

[a] Modified items from Single Parent Adjustment Scale (SPAS) (Singh & McBroom, 1992).

Outside Support of Paternal Role

1. Overall, what is the level of support you get from your extended family members in performing the father role?

Very Unsupportive						Very Supportive
1	2	3	Neutral 4	5	6	7

2. Overall, what is the level of support you get from extra-familial members in performing the father role? (e.g., friends, neighbors, colleagues at work, etc.)

Very Unsupportive						Very Supportive
1	2	3	Neutral 4	5	6	7

3. Overall, what is the level of support you get from institutional resources in performing the father role? (e.g., daycare center, hospital, community center, etc.)

Very Unsupportive						Very Supportive
1	2	3	Neutral 4	5	6	7

The Work-Family (WF) scale[a]

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Moderately Agree	Slightly Agree	Strongly Agree
1. The demands of my work interfere with my home and family life.	1	2	3	4	5	6	7
2. The amount of time my job takes up makes it difficult to fulfill family responsibilities	1	2	3	4	5	6	7
3. Things I want to do at home do not get done because of the demands my job puts on me.	1	2	3	4	5	6	7
4. My job produces strain that makes it difficult to fulfill family duties.	1	2	3	4	5	6	7
5. Due to work-related duties, I have to make changes to my plans for family activities.	1	2	3	4	5	6	7

[a] From the Work-Family and Family-Work Conflict Scales (WF/FWCS) (Netemeyer, Boles, & McMurrian, 1996)

The Bem Sex-Role Inventory Short Form[a]

The following contains 30 personality characteristics. Please rate how well each of the characteristics describes you. Word definitions are provided for some characteristics. Click on for the definition as needed.

	Never or almost never true of me	Usually not true	Sometimes but infrequently true	Occasionally true	Often true	Usually true	Always or almost always true of me
1. Defend own belief	1	2	3	4	5	6	7
2. Understanding	1	2	3	4	5	6	7
3. Warm	1	2	3	4	5	6	7
4. Adaptable	1	2	3	4	5	6	7
5. Willing to take a stand	1	2	3	4	5	6	7

[a] Copyright 1978, 1981 by Consulting Psychologist Press, Inc. All rights reserved. Published by Mind Garden, Inc., Redwood City, CA 94061. www.mindgarden.com.

Note. Permission granted by the publisher to reproduce 5 sample items of the Bem Sex-Role Inventory for inclusion in a dissertation appendix.

Personal Background Questions

1. What is your offspring's age? ( ) years

2. What is your offspring's gender?
    1) Male
    2) Female

3. What is your age? ( ) years

4. What is your marital status?
    1) Single
    2) Widowed
    3) Divorced
    4) Married / Long-term partner

5. Are you currently living with your offspring? (Yes / No)

6. Are you currently employed? (Yes / No)

7. What is your average annual household income?
    1) $0 - $4,999
    2) $5,000 - $9,999
    3) $10,000 - $14,999
    4) $15,000 - $24,999
    5) $25,000 – $34,999
    6) $35,000 - $49,999
    7) $50,000 - $74,999
    8) $75,000 - $99,999
    9) $100,000 and over

8. Please select your highest education level achieved.
    1) Less than 9th grade.
    2) 9th to 12th grade. No completion
    3) High school graduate or completed GED
    4) Some college. No degree
    5) College graduate
    6) Master's degree
    7) Doctoral degree

9. Please select your ethnicity/race.
    1) Anglo-American
    2) African-American
    3) Mexican-American
    4) Asian-American
    5) Native-American
    6) Other (Please specify): _____

10. Overt Affection to Offspring[a]

1. How often do you express affection or liking for your offspring?	Not at all 1	2	3	4	Very 5
2. How close do you feel to your offspring?	1	2	3	4	5
3. How often do you show physical affection to your offspring?	1	2	3	4	5

[a] Modified items from Parent-Child Closeness (PCC) (Buchanan, Maccoby, & Dornbusch, 1991)

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